EFFECTIVENESS OF SOCIAL STORIES IN COPING WITH BULLYING AMONG CHILDREN WITH CHILDHOOD PSYCHIATRY CONDITIONS

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CERTIFICATE

This is to certify that the research work entitled "**EFFECTIVENESS OF SOCIAL STORIES IN COPING WITH BULLYING AMONG CHILDREN WITH CHILDHOOD PSYCHIATRY CONDITIONS"** was carried out by Reg.No.411613002, KMCH College of Occupational Therapy, towards partial fulfillment of the requirements of Master of Occupational Therapy (Advanced OT in Pediatrics) of the Tamil Nadu Dr. M.G.R. Medical University, Chennai.

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ABSTRACT

Aim:

To find out the effectiveness of Social Stories in improving coping skills for Bullying among children with childhood psychiatry conditions.

Methods:

Children were screened through Illinois bully victim scale. 22 participants were divided into experimental and control group. Social stories and role play were given individually for 30 minutes on each targeted behavior and it was structured for 2-3 days a week for 13 sessions. Coping strategies are taught to the children with the help of Social stories for two target behaviors. Control group participants underwent regular occupational therapy session along with coping strategies and role play for 30 minutes individually for 10-13 sessions. COPM and CBSC was administered before and after the intervention as an outcome measure.

Results:

Pretest scores of performance in experimental group had mean value (27.67) and in control group (31.55). The posttest scores of performance in experimental group had mean value (49.54) and in control group (52.15). On comparing the mean values of performance of experimental group and control group (38.08,32.40 respectively) results suggest that children in experimental group performed higher than control group. The comparison of posttest mean values of adaptive strategy components in experimental group and control group (38.08,32.40) reveals that children in experimental group performed (using adaptive responses) higher than control group. However, on analyzing the satisfaction components of COPM in both groups ($p>0.005$) results suggest that children were satisfied on their performance, irrespective of their adaptive or maladaptive strategies. Thus Social story was found to have an impact only on the children's adaptive coping responses and was helpful in learning and using adaptive coping strategies in dealing with bullying situations.

Conclusion:

Social stories are effective in improving coping skills for bullying among children with childhood psychiatric conditions. Social stories enabled application of learnt coping skills (performance) during bullying situation.

INTRODUCTION

School is a learning environment where staff and children engage in learning and in developing social, emotional and academic skills. Interactions are positive and respectful among peer-peer, peer-teacher and teacher-teacher with an atmosphere of trust as well as cooperation and collaboration in the classroom. All children participate in meaningful activities in both curriculum and in extra-curricular by which friendship, kindness and empathy is actively facilitated and promoted among all children

Mistakes and skill deficits are good opportunities to learn and change and to develop appropriate communication, interaction and social skills. School and teachers treat children with their rights and responsibilities and ensure that they play an active role in their social, emotional and academic learning and in eliminating bullying behaviours.[13]

In schools, bullying is a regular occurring behavior problem that is present in almost every school.[1] and is also considered as the commonest form of violence. According to studies it is noted that bullying occurs primarily in the peer group, especially in places where there is only little adult supervision. Developmentally, peer bullying is evident as early as preschool, although it peaks during the middle school years and declines somewhat by the end of high school.[5]

If a child experiences chronic bullying, he or she might perceive his or her school environment as being a frightening place, rates of school absenteeism becomes higher among students who are victimized, decreased level of academic performance and a loss of self-esteem [12] Evidence also suggest that students in special education are at greater risk for victimization and may engage in higher levels of bullying than their typical peers in all contexts and at all ages.[4]

Olweus defined bullying as “any student who is being bullied or victimized is when he or she is exposed repeatedly and overtime to negative action on the part of one or more other students”.[2]According to a study, approximately 30 percent of students between grades 6-10 are involved in bullying, as a perpetrator, victim, or both.[3]

Students are most likely to be bullied in the classroom or in the playground.[6] It is also determined that students with high incidence of disabilities engage in bullying and shows significantly higher rates of reactive perpetration and also experience higher levels of victimization than their same aged peers without disabilities.[7]

Higher rates of being bullied have been reported for children with Special Educational Needs and Disabilities including Intellectual disabilities, Emotional and behavior disorders, Asperger's Syndrome, Autism, cerebral palsy, Developmental Coordination Disorder (DCD), Communication issues: Specific Language Impairment (SLI), Attention Deficit Hyperactivity Disorder (ADHD) Studies also suggest that children with psychiatric disorders or behavior disorders preferably adopt or use aggressive behaviors in response to being victimized. [13]

Both girls and boys are involved in bullying perpetration and victimization, it has been found that boys are involved in bullying at greater rates than girls.[9] while boys tend to be involved in more direct acts of bullying whereas girls are more likely to engage in indirect forms.[10,2]

The responses that children presenting to cope with victimization are related to individual characteristics of the child, such as sex, emotional reaction and the intensity or frequency of a child's victimization experiences.[14] If the child uses maladaptive coping strategies it indicates that they assume as they are the responsible ones for handling stress and take it as a personal responsibility to cope with bullying. Child may also use adaptive coping response at times but do not realize the actual benefit and end up using it very rarely.[12]

For addressing the problems faced by children during bullying and support them to develop adaptive coping responses require a teaching intervention that focuses on children understanding about particular situation and providing them with the ideas of how to respond, what to respond and when to respond to the situation would be Social Stories. Social Story developed by Carol Gray based on evaluations and observations of a child, and target a problematic behavior or a social skill.

Given a growing body of evidence that supports the use of Social Stories with students in the autism spectrum, but there is a lack of documentation for their use with students with other disabilities. Hence, these are used as a teaching intervention to help children understand and behave appropriately in specific social situations hence are considered to be a powerful research tools.[5]

Social stories are applicable to any settings such as home, school and community. They are useful for identifying relevant social cues, introducing new routines and rules, and positively defining desired social skills. Additionally, it can be used mainly to establish the possibility of unexpected occurrences in such a way that the child may understand that the variation is a part of any routine or situation. It is written in such a way to assist a child more accurately in understanding and responding to a target social situation. Thus, Social stories prepare the children to adapt the change calmly in any environment and respond appropriate to a situation.

Need of the Study

Even though studies have been conducted previously,

- Very few studies address intervention strategies for children who are victims of bullying.[7]
- Coping strategies among special educational need children has been studied but does not specifically focused on bullying.
- Uses of Social stories in improving various skills in children has been studied but does not include coping skills with bullying.
- Social stories pertaining to Indian population, social-cultural context are not the same as western socio-cultural context. Thus stories need to be prepared and researched according to our socio-cultural context.

RESEARCH QUESTION

Can Social Stories help in coping with bullying behavior among children with childhood psychiatric condition?

AIM AND OBJECTIVES

AIM:

To find out the effectiveness of Social Stories in improving coping skills for Bullying among children with childhood psychiatry conditions.

OBJECTIVES:

- To identify the victims of bullying among childhood psychiatry conditions.
- To develop coping skills for victims of bullying.
- To determine the effectiveness of Social Stories in developing coping skills for Bullying.

HYPOTHESES

Null Hypothesis:

Social story is not effective in improving coping skills for victims of Bullying among children with childhood psychiatry conditions.

Alternate Hypothesis:

Social Story is effective in improving coping skills for victims of Bullying among children with childhood psychiatry conditions.

OPERATIONAL DEFINITION

BULLYING:

It refers to habitual and repeated acts of intentional verbal, physical or emotional aggression that occur in situations where there is an inherent power differential between two or more individuals.

SCHOOL BULLYING:

It is an unnecessary physical, verbal or emotional behavior seen among school aged children to dominate and gain power over fellow students.

VICTIMIZATION:

It is referring to any individual being made into a victim by other individual or group of individuals.

BULLYING VICTIM:

Children who have been bullied habitually and repeatedly by another child or by group of children

SOCIAL STORIES:

Social story is an individualized short story used to assist children in understanding social situations or circumstances by describing and explaining appropriate behavior and providing them with some examples of appropriate responses.

COPING BEHAVIOUR:

It is an adaptive process used by an individual in a characterized manner with his/her own thoughts, feelings, preferences and actions to deal with any environmental demands or any threatening situation

RELATED LITERATURE

School Bullying was regarded as a typical childhood experience that every child experience through their schooling. It is also considered that every child must learn to deal with bullies by themselves. Hence Bullying was either minimally considered or overlooked as a serious problem. But later the view for bullying was widely considered among schools and educators wanted children to feel safe in order to learn. Thereby gradually, initiative was taken to address bullying, and it was managed effectively.[5]

Over the few decades' education for children with disabilities has gone through many changes. They were educated separately from their peers in either special schools or different classes. But in recent days these children are also included into general education classrooms as educators primarily focuses on their academic success. Even though children are included into regular school setup emphasis on social integration is reduced, providing importance for academic progress is as important to succeed socially. Therefore, peer relationships and interaction are considered to be essential elements needed in competent social skill development during childhood.[20]

As these students are being taught with their less disabled peers, they are subjected to a different range of childhood experiences and may be at an increased risk for bullying. Unfortunately, these experiences are not always positive, and they can have an enormous impact on children immediately or on later stages of life. [29]

COPING WITH BULLYING

Coping is the way in which children respond to victimization, such as seeking help from an adult or friend, seeking revenge, or crying.[30] Coping strategies, the students prefer /use when they are bullied may influence the likelihood and severity of the negative effects. Children employ coping strategies when faced with stressful situation, and this can have beneficial or detrimental effects, depending on the strategy they use.

When coping strategies are adaptive, the negative effects of victimization are reduced. Maladaptive coping, on the other hand, results in psychological maladjustment, passive avoidance, rumination and resignation and decreased academic achievement. Evidence suggests that children anticipate that they will cope with

bullying in adaptive ways, such as asking a friend for advice, seeking help from an adult, or reporting the incident to a teacher However, bullying is characterized by repeated acts of aggression against a victim, using an adaptive coping strategy to real bullying, victimization may seem to be more difficult for children to carry out than they expect.[32]

Researchers suggests that children fall within one of three categories of coping responses. Children are categorized according to their coping responses as good copers, adequate copers, and exceptionally poor copers. Good copers are those who adjust to stressful situations utilizing effective coping skills and integrate stressful experiences into their lives in a positive way. These children, who deal effectively with stress, have five key qualities which includes social competence, problem-solving skills, self-confidence, independence, and achievement orientation. These children attract and use the support of adults at home and school and have a future orientation with realistic goals. The successful copers are sensitive, empathetic, and insightful about their environment and other people. Moreover, they are inner directed and think autonomously.

Adequate copers are considered as survivors because they adequately cope with stress with some effort and adapt to the stressful situation. However, they may not be able to positively integrate the experience and may learn little that can be employed in similar future situations. They may not have the flexibility and inventive creativity of response options, and may not be oriented to future implications of situations.

Lastly, children who do not have the ability to adapt to a stressful situation as they are unable to develop successful coping mechanisms and approach every stressful situation in a disorganized and confused manner. This type of coper may be non-communicative, uncooperative, defensive and easily angered. They may have a generally negative attitude and feel as they cannot control the events that occurs. Coping includes instinctive or reflexive reactions to threats. For children, coping with stress successfully becomes an integral aspect for their continual process of growth and learning.[33]

According to several research social skill deficits and reduced social competence in disabled children are the potential reasons for increase in bullying

situations and response with maladaptive strategies. Many children with disabilities exhibit hesitancy to ask and clarify questions because of the fear of drawing further criticism and are often confused about the instructions / information.

Therefore, teaching children with appropriate coping responses can do much to facilitate the child ability to successfully cope with bullying. By providing instruction in successful coping techniques, coupled with a cognitive effort to eliminate stress in the environment.[33]

SOCIAL STORIES

Social Stories was first created by Carol Gray, she began publishing books and articles with instructions on how to appropriately carry out this intervention. They are short stories that are created based on evaluations and observations of the child. A behavior requiring improvement is targeted. They are written in first person, short and individualized, offering explicit explanations to guide the child through a troubling social scenario. They can also be used effectively in situations where responses and cues need to be taught, when instruction needs to be made more individualized.[28]

In recent times social stories format has been evolved. The stories are constructed using different sentence types. Descriptive sentences are those that explain and describe the scenario to the child and include the description of the setting, the people present, and the sequence. Directive sentences explain what should ideally occur and the behavior that the child should exhibit. Perspective sentences explain how others in the scenario may react and what they might say or do.

Initially, these three sentence types were used to write a social story, but now-a-days other sentence types are also recommended as well. Affirmative sentences offer understanding of the situations. Control sentences sometimes use analogies with the goal of helping the children recall information. Cooperative sentences explain who will help the children in these scenarios and what assistance they may provide. Gray recommends using sentence ratios to build the social story. As more sentence types have been added the ratio has changed as well.[28]

DESCRIPTION OF SOCIAL STORIES[28]

Social Stories should contain these four types of sentence:

- **Descriptive**: factual statements that are opinion and assumption free. They are the only required type of sentence in a Social Story as they often contain the answers to 'wh-' questions. e.g. 'At school our teacher reads to us at the beginning of the day.'
- **Perspective**: statements that describe an individual's internal state (e.g. knowledge, thoughts, feelings, beliefs, opinions and motivations). They are usually used in Social Stories to refer to the internal state of another individual. e.g. 'Most of the children like it when our teacher congratulating us.'
- **Directive**: these identify a suggested response to a situation, and are intended gently to direct a children behaviour. e.g. 'I will try and sit quietly when my teacher takes class.'
- **Affirmative**: these often stress an important point, and may act to reassure the child. e.g. 'This is a right thing to do.'

A proportion of two to five descriptive, perspective and/or affirmative sentences for every directive sentence in a story is also suggested. This ratio should be maintained regardless of the length of a Social Story and applies to the story as a whole. In some cases, directive sentences may not be necessary.

The use of pictures in social stories is an option that needs to be considered depending upon the child. But previously formed Social stories with pictures was said to detract from the main point and recommended not to be used. However, in recent times research, adding pictures may be used to benefit the child. It is important to realize that pictures may keep the child from generalizing the skill beyond the area shown in the illustration, and this will help the child implement the learned behavior into reality.[28,31]

More recently, many companies have begun selling books of prewritten social stories that can be used with children. But ultimately the purpose of a social story is to provide the children with a greater understanding of certain social situations. Without direct assessments of the individual circumstances surrounding a targeted social

situation, it is unlikely that the content of a social story will not be beneficial for all children. Hence Social stories are need to be more individualized for each child. By being individualized, a social story builds on a child's prior knowledge and experiences and helps to extend their own ideas and opinions.

MODES OF SOCIAL STORIES [28]

Social stories may be presented as solely printed words, words and pictures, may be audio or video taped for children. Each story is individually constructed for a child; the primary goal of social story is to provide information rather than instructions. It is noted that the most frequent mistake while writing a social story is the utilization of too many directive sentences so that story becomes nothing more than a rigid set of rules that the child is expected to follow. Directive sentences should also take a point on positive qualities.

STEPS IN SOCIAL STORIES[32]

These are the few steps involved in producing, implementing and evaluating social story program,

- Identify the target behavior or problem situation for social story intervention.
- Define target behaviors for data collection.
- Collect baseline data on the target social behavior.
- Write a short social story using descriptive, directive, perspective and control sentences.
- Place one to three sentences on each page.
- Use photographs, hand drawn pictures, and pictorial icons.
- Read the social story to the child, and model the desired behaviors if needed.
- Collect the intervention data.
- Review the intervention data.

TYPES OF SOCIAL STORIES [28]

There are three basic ways for implementing Social Stories. Selection of the most appropriate technique is highly dependent upon the individual abilities and needs of the target child. Initially for a child, an adult (e.g., caregiver, teacher, Therapist) introduces the story by reading it to them twice by sitting by the side of the child. The

adult then reads the Social Story to the child first, followed by the child reading it back. The adult may read the story with the child several more times in this manner, or until the child is acquainted with the story.

Secondly it can be implemented through audio equipment. Audio implementation is recommended for those individuals who cannot read. The story is recorded onto a tape with pauses in between as it is used to indicate the child like turning the pages of the Social Story.

A third approach to implementing Social Stories is through the use of videotape(s). This approach is used either with students who can read independently or with those who need assistance. On the videotaped versions, the Social Story is read aloud on the videotape with one page appearing on the screen at a time. Videotaped Social Stories make it possible for the story to be read by the target child (volume on) or for the student to read the story himself or herself (volume off).

CHALLENGES OF USING SOCIAL STORES

Although studies show social stories are effective intervention for children with ASD, there are certain limitations. Firstly, it should be used to other childhood psychiatric conditions like ADHD, Learning disability, intellectual disability. Secondly, to be sure to write social stories within the child reading comprehension level. Stories that are too complex will not be effective in communicating the important information to the children. Thirdly, although computers are often of interest to children multimedia social stories have not yet been demonstrated to be effective. Thus, at this point, traditional social stories can be used. Finally, social stories are designed to address certain behavioral needs and should therefore always be implemented as part of a comprehensive educational and behavioral plan.

REVIEW OF LITERATURE

BULLYING IN CHILDREN WITH DISABILITIES

Chad A. Rose, Lisa E. Monda Amaya, and Dorothy L. Espelage[7] (2011) conducted a study to provide a definitions and issues related to **bullying perpetration and victimization** and to synthesize the topic as it pertains to students with disabilities by disability type, personal characteristics, and educational placement. Study suggested that severity of the disability may be a factor in victimization; students with severe disabilities in segregated settings are victimized more often than those in inclusive settings and are this area is covered less in research. The results of these studies revealed that the majority of school children are involved in bully perpetration or victimization, data typically are reported at the whole school level rather than aggregated by subgroups Although many bullying researches has implied a need for social skills interventions, **very few studies address intervention strategies for individual subgroups of students**. Data exists regarding the escalated rates of victimization and perpetration among students with disabilities, this gap in the literature occurs due to inadequate practices or supports for students with disabilities who are subjected to bullying. Schools are incorporating research supported bullying prevention programs into the curriculum. Unfortunately, these programs rarely address interventions for **individualized subgroups of students**. Therefore, **schools also must consider targeted intervention programs for students with disabilities** who either perpetrate bullying or are at greater risk for victimization.

It is widely accepted that **children with intellectual disability (ID)** involve in bullying. In **2011 Nenad Glumbi, Vesna Zuni-Pavlovi[11]** determined specific roles in bullying behavior in children with ID. 61 students with mild intellectual disability 45 males and 16 females, aged from 12.5 to 17.5 who attended elementary or secondary schools for children with intellectual disabilities were taken in for the study. **Majority** of the participants were **not involved in bullying behavior** 11 students were found to participate in bullying, either as bullies (6 boys) or victims (two boys and two girls). In addition, one boy was identified to be the bully-victim. **Students attending segregated educational settings**, such as special schools, self-contained classrooms or resource rooms, have been found to report **a higher incidence of being bullied** than students who attend regular schools It is revealed that **6 out of 61 students** with mild intellectual

disability were **involved in bullying behavior as bullies or victims.** Hence, authors suggest that **all children involved in bullying should receive professional support** irrespective of their school setting.

A cross-sectional study examined the **prevalence of bullying and victimization among children identified as gifted** who are in the last grade of elementary school (4th grade) and first two grades of middle school (5th and 6th grades). **Pelchar**[12] **(2011)** additionally examined the **association of distress experience of children with bullying and victimization** and if the **distress varied systematically across the three grades**. A total of 35 participants [4th grade (n = 15), 5th grade (n = 13), and 6th grade (n =7)]. The **results** indicated that the **4th graders reported a significantly higher prevalence of bullying** compared to the 5th graders. Author recommends that future studies can be done to determine the handling strategies for bullying and victimization by children who are gifted. Thereby the current studies **indicate** there is a **significant, strong association between internalizing distress and victimization as well as externalizing distress and bullying.** Furthermore, **students experiencing distress** should receive **individual counseling**. Another option is to provide these **students with group guidance counseling or social skills training** that focuses on **avoiding bullying situations and coping with the aftermath of bullying when it occurs.** Finally, as a **suggestion**, **a box can be kept in the main office** and inform the students to **write their name on a slip of paper** and place it in the box if they wish to see him or her to **talk about their concerns regarding bullying and victimization.**

Ida M. Malian[18] **(2012)** conducted a qualitative study on **students with Disabilities in Inclusive Settings to differentiate Bully versus Bullied**. Study discuss about the **bullying patterns and trends of students with and without disabilities in inclusive settings**. Eight, 4th grade students, two females and 6 males, ranging in age from 9 years to 10 years old with eligible for receiving special education services in inclusive, resource and self-contained settings were **observed during class and in specials and non-academic times**. General observations revealed that the **students had physical characteristics like larger or smaller in stature, had glasses or hearing aids, used a wheelchair that set them apart from their typical peers and** students with **communication issues**, have increased the likelihood of **being targeted**.

The data found that a student disability was "so significant and **students' responses to verbal provocation** so visible that they are **targeted frequently**. It also suggests that **students with disabilities are bullied and are themselves bullies at times** and there is a relationship between **personal characteristics and the incidence of bullying**. Further, **professional development** emphasizing on appropriate intervention plans and classroom discussion embedded in lesson should be conducted with appropriate follow-up in the classroom.

The purpose of **Rose, C. A., & Espelage, D. L. (2012)**[19] study was to evaluate the extent to which students with and without disabilities differed on bullying, fighting, victimization, and anger. Additionally, to isolate students with Emotional Behavioral Disorder [EBD] and compare them to students with disabilities other than EBD on measures of reactive aggression (i.e., fighting) and proactive aggression (i.e., bullying). Participants included 163 seventh and eighth grade students with disabilities from four public middle schools, between the ages of 12 and 15. Results shows **that students with disabilities engage in higher levels of fighting and bullying behaviors, and are victimized** more than students without disabilities. Students with disabilities who are **victimized often report higher levels of rejection from peers and are regarded as unpopular**. It was determined that students with **EBD engaged in higher levels of bullying and fighting behaviors** than other subgroups of students, while **higher levels of victimization** predicted higher levels of bullying for students with disabilities other than EBD.

Bonnie Bell Carter and Vicky G Spencer (2006)[20] provides an **overview of research addressing bullying and students with disabilities**. Reported forms of bullying included **name-calling, teasing, physical attacks, severe verbal bullying, verbal aggression, threats, taking belongings, imitating, and making fun** of the students with disabilities. The students with disabilities also tended to be **less popular, have fewer friends, and struggle with loneliness**. The sample included a total of 609 students who were identified with disabilities. In order to make comparisons between the disabilities and the degree of bullying, studies divided into two disability categories: visible and non-visible. Reports suggest that **girls were more at risk than boys for being victims** of bullying and having problems decoding social situations. Students with LD, ADHD had fewer friends than their peers. Collectively, some studies report

that students with **visible disabilities were bullied more than their nondisabled peers**. Studies identified **name-calling as the most common form of bullying**. Students with **ADHD were at an increased risk for being victimized and for victimizing others**. Author suggest that having a disability may place students at an increased risk to engage in bullying behaviors and some characteristics of students with disabilities, are **low self-control, poor socials skills, and less language facility**, may increase the possibility of these students involving in bullying others.

An article by **Stella Chatzitheochari, Samantha Parsons, Lucinda Platt (2016)**[21]enhances the understanding of **bullying experiences among disabled children in both early and later childhood**, by collecting data from the Millennium Cohort Study and the Longitudinal Study of Young People in England. Longitudinal research discovered that early bullying experiences have a **strong negative impact on social and psychological outcomes later in life**, above the influence of other risk factors. Data analysis confirms that disabled children and young people in England are facing **'double disadvantage'** including both contexts and socio-economic disadvantage that is associated with disability, and, there is an **increase in risk of bullying** and its adverse consequences, during **critical periods of children school careers and development**. Hence this study suggests the importance of **incorporating the role of bullying into future studies** focusing on the outcomes of childhood disability and include within the theoretical aspects of disabilities.

Rose, C. A., & Monda Amaya, L. E. (2011)[4] provides a fundamental understanding of bullying behavior and strategies for intervening in schools and classrooms. In their article they **established bully prevention strategies for students with disabilities** within the context of a multitier framework including **Teacher-Facilitated Strategies for Student Behavior and Classroom Strategie**s for **addressing bullying through targeted interventions**. In connecting bully prevention targeted interventions for chronic bullies and victims become necessary components of any anti-bullying program. By establishing appropriate intervention, teachers will be able to address social deficits by **facilitating student to increase a sense of independence, teaching self-management strategies for students to recognize behaviors** that may place them at risk for increased involvement, and **teaching socially appropriate replacement or alternative behaviors that may decrease the risk of**

involvement for promoting self**-determination in both bullies and victims with disabilities.**

Dorothy, L. Espelage, Chad, A. Rose, and Joshua, R. Polanin. (2015)[24] designed **Social-Emotional Learning Program (SEL)** to reduce Bullying, Fighting, and Victimization among middle school students with disabilities. 6th to 8th grade curriculum included 41 lessons that focused on **social-emotional learning skills**, including empathy, bully prevention, communication skills, and emotion regulation were implemented by teachers. Therefore, in this study, it is stated that direct instruction in the areas of self-awareness, social awareness, self-management, problem solving, and relationship management would serve as a **vehicle to reduce bullying, victimization, and fighting over time for students with disabilities**. More specifically, SEL program allowed students with disabilities to be more **specific on proactive types of behaviors,** while actively managing their own behaviors. Results indicates a significant reduction in bully perpetration; compared with control group and the scores of **Bullying perpetration scale significantly decreased in intervention students** across this 3-year study.

COPING WITH BULLYING IN DISABILITIES

Parris, Leandra N. (2013)[25] conducted a study on the development and application of the **Coping with Bullying Scale for Children (CBSC)**. The aim was to examine the **CBSC in relation to the Multidimensional Model for Coping with Bullying** and investigate the relationship between coping style and student outcomes of depression, anxiety, and social stress. Additionally, relationships between coping, victimization, and student engagement in bullying behavior was also examined. Data analysis suggested a 4-factor coping structure: **constructive, externalizing, cognitive distancing, and self-blame. Externalizing coping** was found to be the **indicator of depression** while **constructive and self-blame coping** was **associated with more social stress** and also predicted **higher rates of anxiety**. Results indicated that **more frequent victimization predicted the use of constructive and self-blame strategies**, while students more often engaged in **bullying behaviors** indicated a **higher use of externalizing and self-blame**. On the other hand, **increase in self-reliance was predictive of constructive coping, cognitive distancing, and self-blame. Future suggestion** provides that by examining the relationship between **students' perceptions**

of themselves and their chosen coping strategies would further illustrate the reason behind students choosing certain strategies over others and could **lead to potentially effective interventions and preventive strategies.** The coping strategies that are used by the students when they are bullied may influence the severity of negative effects.

In the study conducted by **Christopher Donoghu (2014)**[14], examines the **predictions made by students in two middle schools about the ways they would cope with becoming a victim of verbal and social bullying** and also **analyzed the influence for coping strategies and student willingness to seek help with bullying at school**. The results indicated that students with **recent experiences of victimization** are more likely to **cope in maladaptive ways** and if **victimized in the future** will use **internalizing or externalizing coping strategy.** Future educational interventions suggest that by introducing realistic forms of conflict or use of the real experiences of students as **teaching method** for intervening victimized students in one-on-one sessions to encourage the use of approach strategies**.**

SOCIAL STORIES – AN INTERVENTION FOR BULLYING

Erin Eckelberry (2007) done a study **using Social Story for children with Autism, Learning Disabilities and ADHD".** There are many **studies that supports the use of social stories with students in the autism spectrum**, but there is a **lack of documentation for their use with students with other disabilities.** This study involved three first grade subjects, for which a two-week social story intervention was completed. Student A, a female, showed the most positive behavior change, based on her target behavior of defiant outbursts. Student B, a male, targeted inappropriate kissing, and showed some positive results. Student C, whose target behavior was putting non-food items in his mouth, showed very little behavior change. Overall, **all three students showed that by day ten they could answer comprehension questions based on their social stories with 100% correctness.** The data shows that their understanding of the text was of high enough understanding that they could share some of the meaning behind the words and provide answers that demonstrated comprehension.

Elizabeth .C.H (2015) investigated the **effectiveness of social stories as an intervention method for children diagnosed with Autism Spectrum Disorders and Related Developmental Disorders**. The participants were between ages 2-15 years old, previously been diagnosed with ASD or a similar disorder. Social story methods varied according to the setting of implementation, the implementer, the age and diagnosis of each participant, and the structure of the specific social story. Research shows that the **social story method is an effective intervention for most children with ASD regardless of the characteristics the social story holds**. The participants' **target behaviors decreased, to some degree**, and social story work as **a positive intervention method** for children. They also suggested that **personalized social stories might benefit children at a higher rate** and peer-mediated group work, this social story method was shown to be effective.

A comprehensive review of 28 studies was conducted to evaluate the impact of social stories intervention and 18 studies in meta-analysis of the social stories was conducted by **David w. Test (2011)**[34]. Eighteen of the twenty-eight studies that included in the meta-analysis to determine the effect of Social Stories interventions on the knowledge and skills of individuals with disabilities. Though **outcome indicated positive effects on participants' behavior lack of experimental group, weak treatment effects, or confounding treatment variables** in reviewed studies would made it difficult in determining the effectiveness of social stories is the sole responsible for changes in social **behavior, thus it is premature to suggest social story to be ab evidence based practice. Therefore, out** of **18 studies only 2 collected generalized data and 8 collected maintained data and only few studies on long-term and carry over effects of social stories**. Finally, future recommendation suggests to provide evidence of targeted skill and amount of behavior change which are socially important. **Future researchers are encouraged to provide accountability through formative data to determine the effectiveness of Social story for individual student.**

CONCEPTUAL FRAMEWORK

Children with various psychiatric disorders such as Autism, ADHD, LD etc. exhibit inappropriate social behaviors. This can be viewed as due to lack of social understanding and poor social judgement that the children engage in inappropriate behaviors. The child has difficulty in understanding the cues from the environment thus fails to modify his /her behavior accordingly. Therefore, a child with social skill deficit need to understand the environment and its reaction to various behaviors.

Children with complaints of victimization assumes school environment to be stressful and their perception of stressful situation, prior experience and support systems are the determinants of their ability to cope. Children who have a positive self-image and receive support from home, school, and other significant adults are better equipped for handling the typical stresses often found in childhood.

Lazarus and Folkman observed children employing two types of coping strategies,

a. Adaptive coping strategies

b. Maladaptive copping strategies

When faced with a variety of different stressors, and this can have beneficial or detrimental effects, depending on the strategy employed.

Causey & Dubow created two scales for classifying coping behaviours,

a. approach strategies

b. avoidance strategies

Children who utilize **adaptive / approach strategies** either rely upon themselves to solve problems or call upon social support from friends, family or teachers are having higher chances of the reduction in negative effects of victimization and are linked to positive functioning.

Maladaptive / avoidance coping, on the other hand, such as distancing (e.g. acting as if nothing occurred), internalizing (e.g. keeping their emotions to themselves) or externalizing (e.g. taking their emotions out on others) can result in psychological maladjustment, passive avoidance, rumination and resignation, substance abuse, and decreased academic achievement.

Victims of bullying frequently have a low self-concept and lack self-confidence. They often, maintain few close and are not directly invited by their peers to participate in any social or extracurricular activities. However, it is important for children with disabilities to increase
social competence and develop peer associations to decrease exposure to victimization.

Cognitive-behavior therapy (CBT)[36] is among the most widely used psychosocial interventions for all populations. It is based on the theory that maladaptive thoughts, feelings, and behaviors interrelate to sustain psychopathological or maladaptive symptoms and behaviors.

Thus, CBT interventions typically focus on more accessible domains like in the current study changing thought or behavior pattern of children e.g. 'It is okay if my friend calls me with funny names, it is okay when my friend hitting me for fun while playing'

CBT interventions are often delivered one to one to develop realistic goals and comprehensible feedback as a progress from children. Interventions that are CBT-based tend to be fairly time-limited (often fewer than 16 sessions), focus on a collaborative and problem-solving relationship between therapist and children, and emphasize thinking in more logical or helpful ways.

CBT has been practiced among children with disabilities who have average cognitive ability and for school-aged population as a method to ameliorate social-communication deficits. These social skill training programs are in practice used as intervention as a broad approaches including Social stories as a primary approach.

Conventional CBT programs primarily focus on affective education but when considering therapy programs for children with special needs, consideration is in social competency**.** Therefore, Social stories intervention is used to help children understand and behave appropriately in a specific social situation and develop their social competency.[5]

As mentioned by researchers' social skills are "behaviors that must be taught, learned, and performed," and social competence represents judgments or evaluations of those behaviors within and across situation". Social competence included in the current study are making the children identifying and interpreting cues in the environment (to look

for teachers when someone teases). In addition, students should identify feelings in themselves and others that can guide their choices and help them interpret situations appropriately, e.g. 'when my class mate calls me with names I get upset, that doesn't mean I should also do the same. I should not hurt him if I become friend with him he will stop calling me names'.

Increasing social competence may begin with helping children understand how to capitalize on their strengths and recognize strategies for overcoming social difficulties and create opportunities for positive interactions. One common method of increasing social competence among students with disabilities is the use of Social Stories. Social stories are an intervention used to help children understand and behave appropriately in a specific social situation.[5]

Cognitive restructuring is a technique that was utilized in social story from CBT which enables the children to correct distorted conceptualizations and dysfunctional beliefs. The process involves challenging their current thinking with logical evidence and ensuring the rationalization of their emotions.

In the current study therapist encourages the children to be more flexible in their thinking and to seek clarification using 'rescue' comments such as "are you joking?" when someone calls you with funny name' or "I'm confused about what you said" when someone teases you'. Such comments used by the children will help them to rescue from the situation.

This would enable a child to understand the consequences of their response as well as knowledge in appropriate behaviour to positively influence an environment. Thus children benefit from this social skill training program to develop social skills and apply learned skill across settings.

Occupational Therapy Levels of Intervention:[35]

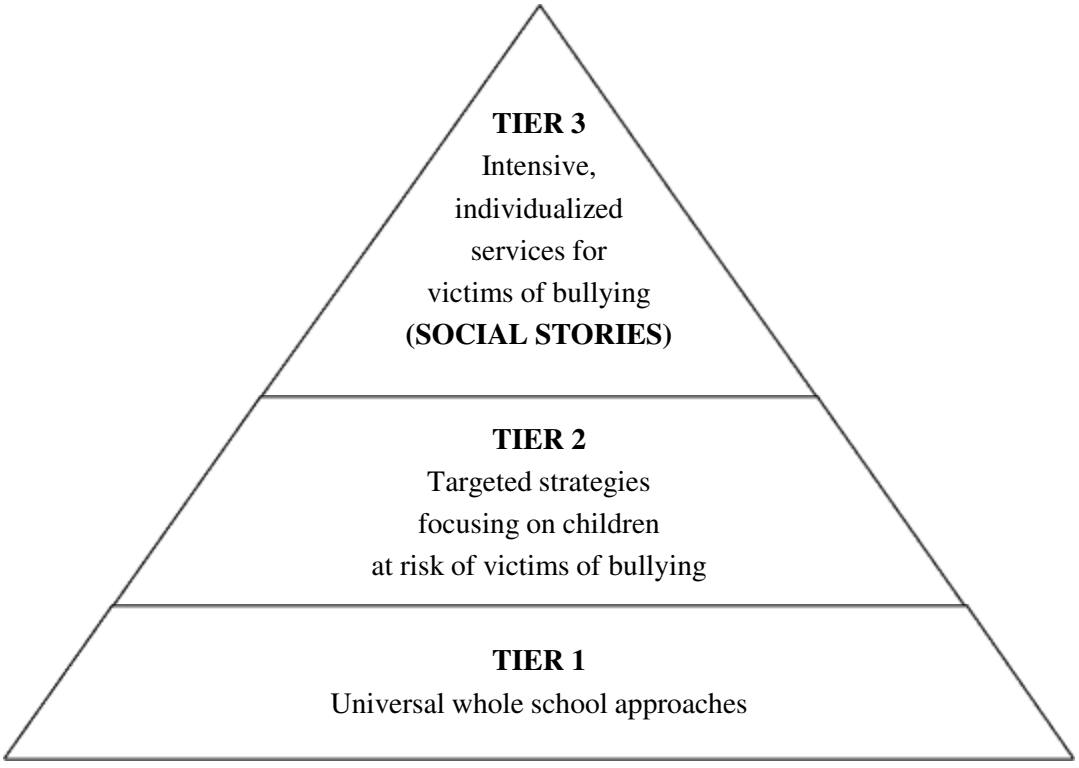
- Occupational therapy intervention for victimization serve an important role in helping children prevent from bullying, promote positive student interactions, participation in enjoyable occupations, using adaptive coping strategies and fostering friendships with peers at school setting.

❖ Interventions are classified into three tiers

- **Tier 1:** Universal, whole school approaches - contributing to school-wide Positive Behavioral Interventions & Supports and Social Emotional Learning efforts.
- **Tier 2:** Targeted strategies focusing on students at risk of bullying-the Victims.
- **Tier 3:** Intensive, Individualized services for children i.e. the victims of bullying.

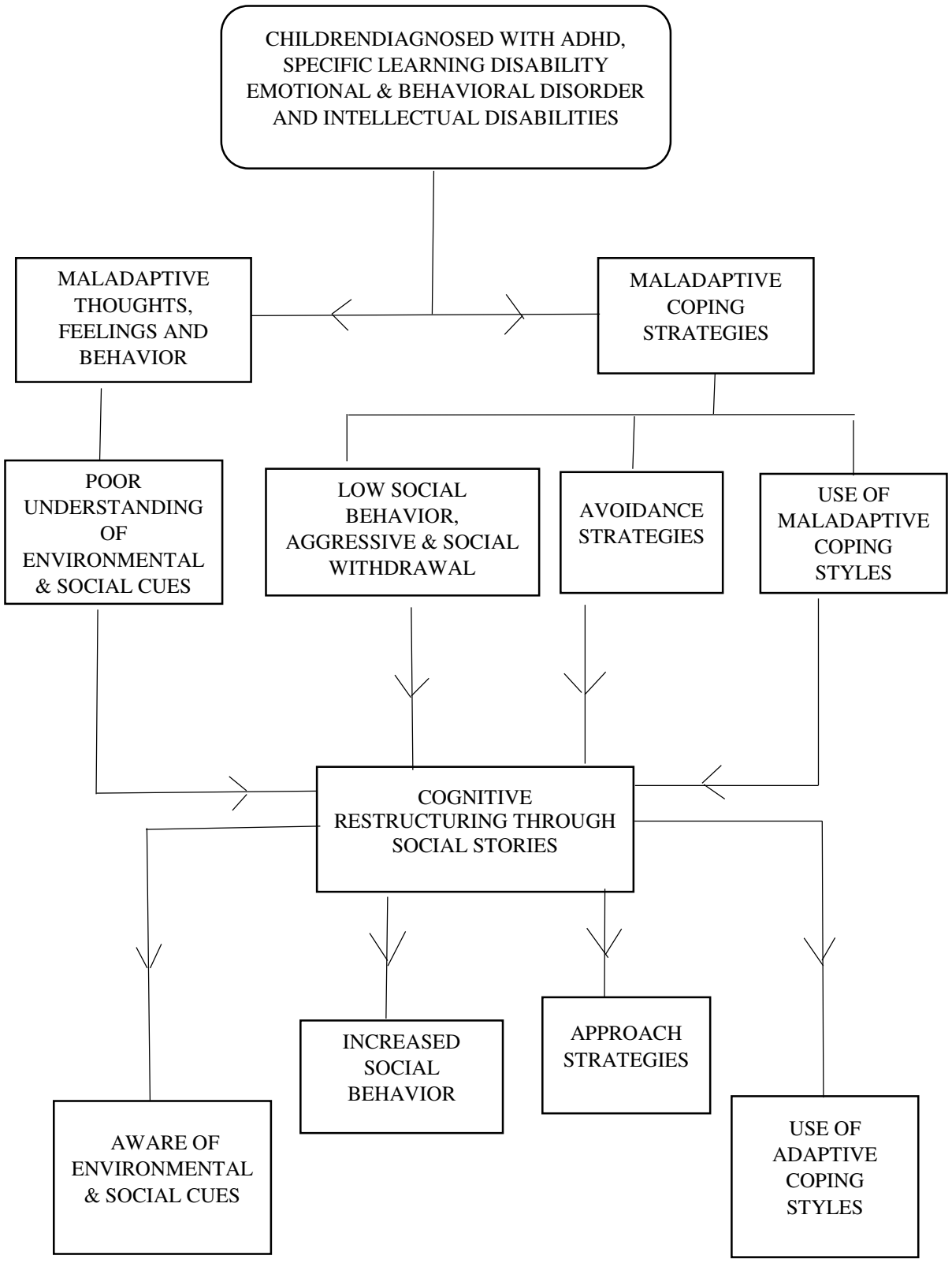
❖ Occupational therapists identify the adaptive or maladaptive behaviors within an environment and correct it with the expected behaviour in order to facilitate the successful occupational performance.

INTERVENTION STRATEGIES FOR BULLYING WITHIN A MULTITIER FRAME WORK



- Therefore, with consistent to multitier framework, tier 3 provides intensive individualized services for victims of bullying. Hence social stories being individualized is considered as an intervention strategy for targeting victims by providing an opportunity for the children to use appropriate behavior when faced with victimization.
- Thus the present study aims to determine effectiveness of Social Stories in improving coping skills for bullying among children with childhood psychiatry conditions

SCHEMATIC REPRESENTATION OF THE CONCEPTUAL FRAMEWORK



METHODOLOGY

PLACE OF STUDY:

The study was conducted at Kovai Medical Center and Hospital, Coimbatore and at St. John's Matric.Hr. Sec.School, Press Colony, Veerapandi Pirivu, Coimbatore-19.

STUDY DESIGN:

- The study is Quantitative, two group pre-test and post-test quasi experimental design.
- The study involves a control group and an experimental group.

TARGET POPULATION:

Children with Childhood Psychiatric conditions are the target population for the study.

SAMPLE SIZE:

22 (12 in experimental group and 10 in control group)

SAMPLING TECHNIQUE:

Convenient sampling

SELECTION CRITERIA:

Inclusion Criteria:

- Children within the age group of 8 years to 13 years.
- Both boys and girls going to regular school or inclusive school.
- Children with childhood psychiatric conditions such as Learning disability, mild intellectual disability, ADHD as diagnosed by a Pediatrician or Psychiatrist.
- Children with basic understanding capacity and verbal skills.
- Children who scored more than 50% of score in victim subscale of Coping with bullying scale for children [CBSC]

Exclusion Criteria:

- Children with co-morbid physical dysfunctions were excluded.
- Children with vision and hearing impairment.

VARIABLES IN THE STUDY:

Independent Variable:

- Social stories with coping strategies and role play (experimental group)
- Coping strategies and role play (control group)

Dependent Variables:

- Coping behavior
- Performance and Satisfaction of Target behavior. (both group)

Extraneous Variables:

- Environment and family situation
- Social skill training

Confounding Variables:

- Children previous ideas about bullying situation and their responses

TOOLS USED IN THE STUDY:

These are the scales used to screen the children for inclusion criteria and to measure the pre-and post-intervention effect.

Screening tool:

- Illinois Bully-Victim scale

Outcome measure:

- Coping with Bullying Scale for Children (CBSC)
- Canadian Occupational Performance Measure (COPM)

ILLINOIS BULLY-VICTIM SCALE:

The Illinois Bully Scale is an 18 item, self-report measure that contains three subscales for measuring the frequency of fighting, peer victimization, and bully behavior. The Bully subscale consists of 9 items that address how often a youth (8-13 yrs old) engaged in bullying (perpetration) behavior primarily in the form of social aggression.

The Victim subscale consists of 4 items that address both physical and verbal types of victimization by peers. Remaining 5 items assess physical fighting.

Scoring:

- Point values are assigned to each response; (Never = 0) (1 or 2 times = 1) (3 or 4 times = 2) (5 or 6 times = 3) (7 or more times = 4)
- Summary of scores for subscale is by adding responses
  a. Bully subscale: Items 1, 2, 8, 9, 14, 15, 16, 17, and 18
  b. Victim subscale: Items 4, 5, 6, and 7
  c. Fighting subscale: Items 3, 10, 11, 12, and 13
- The Bully subscale score ranges from 0-36;
- **The Victim subscale score ranges from 0-16;**
- The Fighting subscale score ranges from 0-20.
- **Higher scores reflect higher levels of victimization.**

Psychometric Properties: Cronbach's alpha coefficients were 0.87 for the total scale, 0.71 for victims, 0.77 for bullying, and 0.76 for the fighting subscales; all of which were satisfactory.

COPING WITH BULLYING SCALE FOR CHILDREN (CBSC)

The CBSC (Parris et al., 2011) was developed to examine coping strategies that victims utilize to address bullying. It includes the prompt "When you are picked on, how often do you…?". It consists of **thirty items with five items** from category of coping from the Multidimensional Model of Coping with Bullying [MMCB] (Parris, in

development): problem-solving, physical distancing, cognitive distancing, and cognitive approach (e.g., reframing, self-blame), and externalizing strategies.

Scoring:

- Participants will rate how often they each coping strategy in response to bullying on a 4-point Likert scale.
- Scores are calculated separately for both Adaptive and maladaptive strategies.
- Adaptive coping strategy is rated based on 0(never) / 1(Sometimes) / 2(Often) / 3(almost always) and for Maladaptive coping strategy it is rated ranging from 3 (never) / 2(sometimes) / 1(often) / 0 (almost always).
- Summary scores of each coping categories are obtained by adding their responses respectively.
- Higher scores in adaptive coping strategy indicates children using adaptive coping response and higher scores in maladaptive coping strategy reflects that children using minimal coping responses.

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE (COPM)

The Canadian Occupational Performance Measure (COPM) is an individualized criterion-based measure of occupational performance designed for use by occupational therapists to determine and prioritize intervention goals in which clients rate the level of importance, performance, and satisfaction with goals in areas of self-care, productivity, and leisure on a 10-point scale and to detect self-perceived change in occupational performance problems over time.

In this study, modification is done in the areas of occupational performance. The children will consider their behavioral responses during bullying situation and rate their level of important in target behavior and their coping performance and satisfaction in dealing with bullying

Scoring: Initial assessment & Reassessment

- Child is asked to identify his/ her 3 most important bullying situation.
- Once the specific problem is identified, child is asked to rate the importance of each problem on a 1- 10 scale.
- Based on the importance, child is then asked to rate their ability to perform in bullying situation and their satisfaction with that performance using the same scale of 1 – 10.

- The ratings of the ability in each performance and satisfaction are then multiplied by importance rating to determine initial assessment scores.
- After the intervention program reassessment is taken and child is asked to rate their performance in bullying situation and satisfaction with the performance.
- These ratings are then multiplied by original importance rating and are summed and divided to calculate the change over time.

Psychometric Properties

- Reliability – 0.63 and 0.84
- The range of Test-Rest value -0.79 and 0.75
- The range of internal consistency for performance is 0.41, -0.56 and satisfaction is 0.71

PROCEDURE:

An approval from the ethical committee, permission from the Institutional head and consent from the parents and special educators were attained.

SCREENING

- The samples were screened using the Illinois Bully-Victim scale.
- Children who got higher scores under Victim subscales were taken as a target population for the study.

INITIAL ASSESSMENT

- A pretest was performed for the target population using Coping with Bullying scale for children which will provide the coping strategies used by the children.
- Children choose two main target behaviours which were important to them. Such as calling names, hitting purposefully, teasing etc. The details of behaviour are shown in appendix.
- Canadian Occupational Performance Measure (COPM) was given and asked to score based on above mentioned targeted behaviors.
- Children were categorized into an experimental group and a control group.
- 22 children were randomly assigned in the 12 children in experimental group and 10 children in the control group after the pretest.

INTERVENTION - EXPERIMENTAL GROUP

- After the pretest, the experimental group were introduced to the intervention program consisting of 13 individual therapy sessions of Social stories with role play
- The experimental group underwent regular occupational therapy session along with 30 minutes of Social stories with coping strategies individually by keeping two behaviors as targeted behavior.
- Social stories with coping strategies were prepared as flash cards for each target behavior with pictorial representation.
- Social stories were given individually for 30 minutes on each targeted behavior and it was structured for 2-3 days a week for 13 sessions.
- Coping strategies are taught to the children with the help of Social stories for two target behaviors.
- First social story is Simon's story, it is introduced to the children for addressing the first target behavior 'name calling'. Coping strategies were explained by the therapist to the children with the help of this story. Then therapist will ask questions about the story to confirm the comprehension of the story and it is recorded as incorrect/ correct responses. Later according to the child's responses, the maladaptive behavior, its negative consequences are corrected with the alternative adaptive behavior and its positive impact on self and the environment.
- After the narration of the story the child is asked to explain the story by observing the pictures from the flash cards and a role play is conducted between therapist and the child with few questions at the end of the session.
- With the successful completion of first story, second social story- Tony's story is introduced to the child addressing the second target behavior 'hitting, beating, and pushing.
- The therapist explained the coping strategies in different context, using the social stories. E.g. while children playing in playground, during classroom hours, at hostel, while going out to public places etc.

CONTROL GROUP

- Children in control group were introduced to coping strategies for 10-13 sessions along with role play.
- The control group participants underwent regular occupational therapy session along with coping strategies and role play for 30 minutes individually for 10-13 sessions.
- Coping strategies are introduced to the children for first target behavior 'name calling' Then therapist will ask questions to confirm the comprehension of the strategies taught and it is recorded as incorrect/ correct responses. Later according to the child's responses, the maladaptive behavior, its negative consequences are corrected with the alternative adaptive behavior and its positive impact on self and the environment.
- After completing teaching coping strategies for first target behavior, second target behavior 'beating, pushing, and hitting was addressed.
- After teaching the coping strategies at the end of each session a role play is conducted between therapist and the child.

These are the few coping strategies taught to children for experimental group and control group

Targeted behavior	**Coping Strategies**
Name calling	Do little or nothing
	Agree with the bully
	Distract the bully, change the subject
	Laugh or make a joke
	Stay away from the bully
Hitting, pushing and beating	Tell your teachers and parents
	Stay near adults so the bully wont bully you
	Keep friends near you to keep the bully away
	Become friend with the person who bullies at you
	Look at the bully and write their names in a paper
Common adaptive strategies	Count from 10-1 backwards
	Think about positive things in your life
	Make a plan and try to find ways to make the bully stop
	Accept that it has happened and can't be changed

REASSESSMENT

- At the end of completion of intervention both the experimental group and control group were assessed using the CBSC AND COPM to evaluate the coping strategies used by the children and the performance, satisfaction levels to their target behaviors post intervention.
- The provided data are then subjected to statistical analysis.

DATA ANALYSIS

The aim of this study was to find out the effectiveness of using Social stories in improving coping skills for Bullying. The study was conducted in 22 children with childhood psychiatric disorder between the age group of 8-13 years. The participants were divided into two groups - the experimental group with 12 children and control group with 10 children. The experimental group received social stories and the control group received coping strategies training.

STATISTICAL DESCRIPTION OF THE VARIABLES

The scores of experimental and control groups were subjected to statistical analysis which was done using SPSS version 20. Descriptive analyses were performed to characterize the groups and inferential analyses to compare the performance of the groups (Mann Whitney U, Wilcoxon) were used.

WITHIN THE GROUPS COMPARISON

The measurement was analyzed using the Wilcoxon signed rank test separately for both the groups.

- Comparison of pretest and posttest scores of COPM components in experimental group and control group (table 4.1,4.2,4.3,4.4)
- Comparison of pretest and posttest scores of CBSC components in experimental group and control group. (table 5.1,5.2)

BETWEEN THE GROUPS COMPARISON:

The measurement was analyzed through the Mann Whitney U test.

- Comparison of COPM test scores between the experimental and control group (table 7.1,7.2,7.3)
- Comparison of CBSC test scores between the experimental and control group (table 8.1, 8.2)

EFFECT SIZE:

- Comparison of effect size between experimental group and control group (table 6.1)

Effect size was calculated with the formulae,

$$d = M_1 - M_2 / \text{Spooled}$$

$$\text{Spooled} = \sqrt{[(SD_1^2 + SD_2^2) / 2]}$$

Where,

d is the descriptive measure (difference between the means) Cohen's

M_1 and M_2 are means of posttest and pretest scores of each individual group.

Spooled is the pooled standard deviation (the square root of the average of the squared standard deviations SD_1 and SD_2) of each individual group.

An effect size of □0.2 to 0.2 is considered to be a small effect

An effect size of 0.3 to 0.5 is considered to be a medium effect

An effect size of 0.6 to >0.8 is considered to be a greater effect

TABLE 1: DEMOGRAPHIC DETAILS

S. NO	GROUPS	NO. OF PARTICIPANTS		MEAN AGE
		BOYS	GIRLS	
1.	EXPERIMENTAL	11	1	10.75
2.	CONTROL	10	0	10.70

TABLE 2: DESCRIPTIVE DETAILS OF EXPERIMENTAL AND CONTROL GROUPS

EXPERIMENTAL GROUP			CONTROL GROUP		
DIAGNOSIS	N	%	DIAGNOSIS	N	%
LEARNING DISABILITY [LD]	7	58.3	LEARNING DISABILITY [LD]	4	40
ADHD	3	25	ADHD	4	40
MILD ID	2	16.6	MILD ID	2	20
TOTAL	12		TOTAL	10	

TABLE 3.1: DESCRIPTIVES OF THE PRE TEST AND POST TEST SCORES OF THE COPM AND CBSC COMPONENTS FOR BOTH EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLES		GROUP	PRE-TEST		POST-TEST	
			MEAN	SD	MEAN	SD
COPM	Performance	Experimental	27.67	7.29	49.54	6.98
		Control	31.55	10.57	52.15	8.472
	Satisfaction	Experimental	22.13	4.99	45.17	13.41
		Control	25.60	5.73	46.75	7.84
CBSC	Adaptive strategies	Experimental	16.58	3.02	38.08	4.69
		Control	15.60	4.60	32.40	6.31
	Mal adaptive strategies	Experimental	21.25	556	29.28	4.25
		Control	22.90	3.51	29.10	1.91
	Total score	Experimental	37.50	6.93	68.42	6.54
		Control	37.20	7.95	61.50	5.60

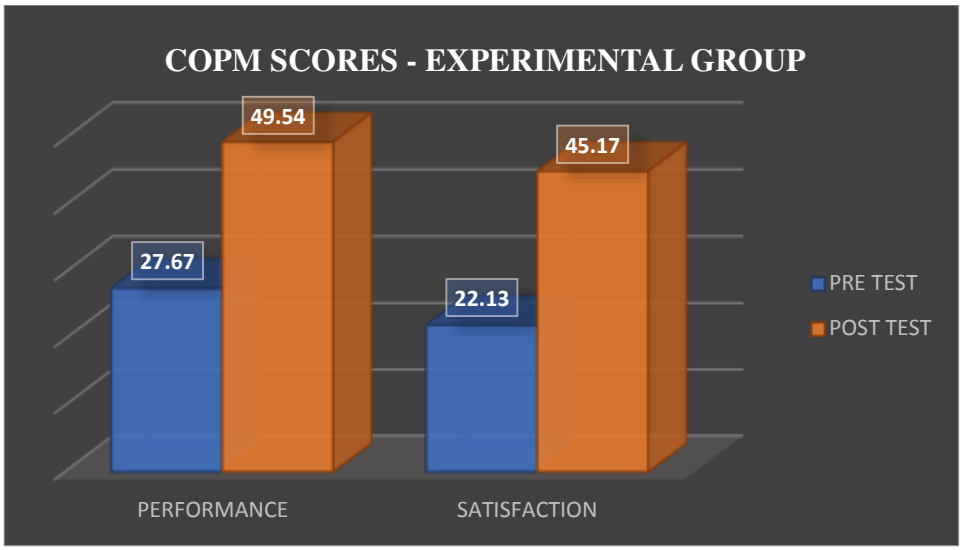
The above table shows the means and standard deviation values of pretest and post test scores of all the components of Canadian Occupational Performance Measure (Performance and Satisfaction), Coping with Bullying Scale for Children (Adaptive strategies, Maladaptive strategies and total scores) from both the experimental group and control group.

TABLE 4.1: COMPARISON OF PRETEST AND POST TEST SCORES OF COPM COMPONENTS IN EXPERIMENTAL GROUP

VARIABLES POST - PRE	N	RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig p value
Performance	12	Negative Ranks	0	.00	.00	-3.06	**.002**
		Positive Ranks	12	6.50	78.00		
		Ties	0				
Satisfaction	12	Negative Ranks	0	.00	.00	-3.06	**.003**
		Positive Ranks	12	6.50	78.00		
		Ties	0				

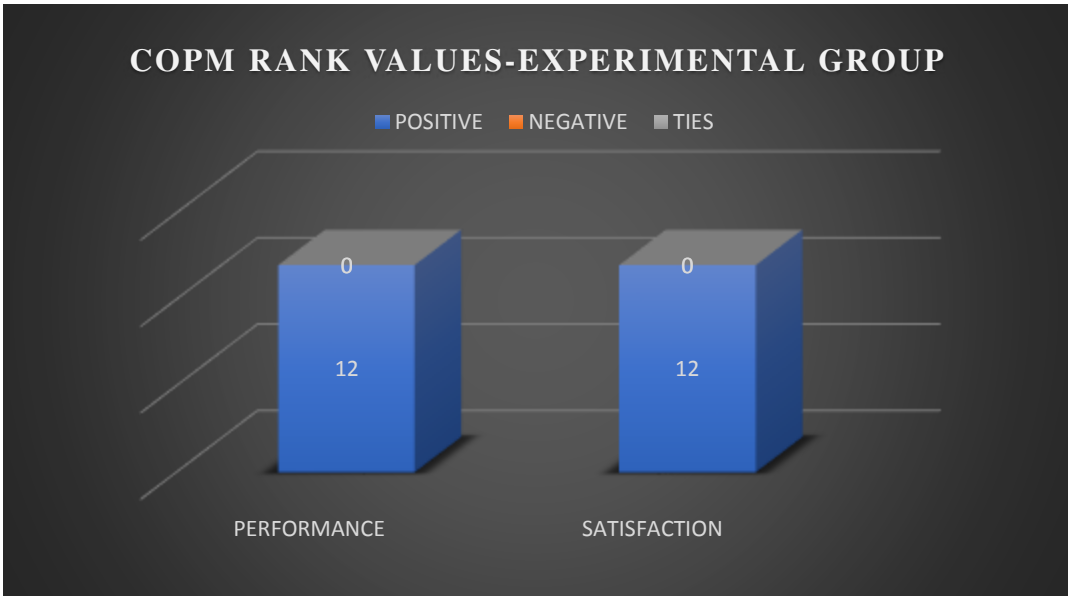
The above table 4.1 displays a statistical significant difference between pre and post test scores of performance and satisfaction component.

GRAPH 4.1:



Graph 4.1 illustrates the comparison of mean values of pretest and posttest scores.

GRAPH 4.1a



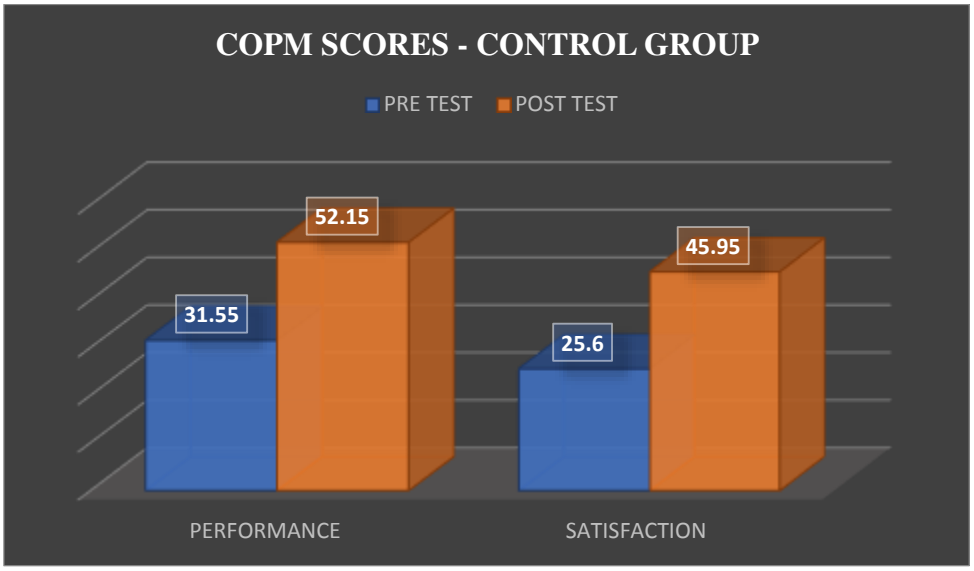
From the graph 4.1a positive ranks indicates high scores of posttest and negative rank indicates high scores of pretest, this explains that post test scores were higher than the pre-test scores in performance for all subjects indicating that all of them have improved.

TABLE 4.2: COMPARISON OF PRETEST AND POST TEST SCORES OF COPM COMPONENTS IN CONTROL GROUP

VARIABLES POST – PRE	N	RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig p value
Performance	10	Negative Ranks	0	.00	.00	-2.80	**.005**
		Positive Ranks	10	5.50	55.00		
		Ties	0				
Satisfaction	10	Negative Ranks	0	.00	.00	-2.80	**.005**
		Positive Ranks	10	5.50	65.00		
		Ties	1				

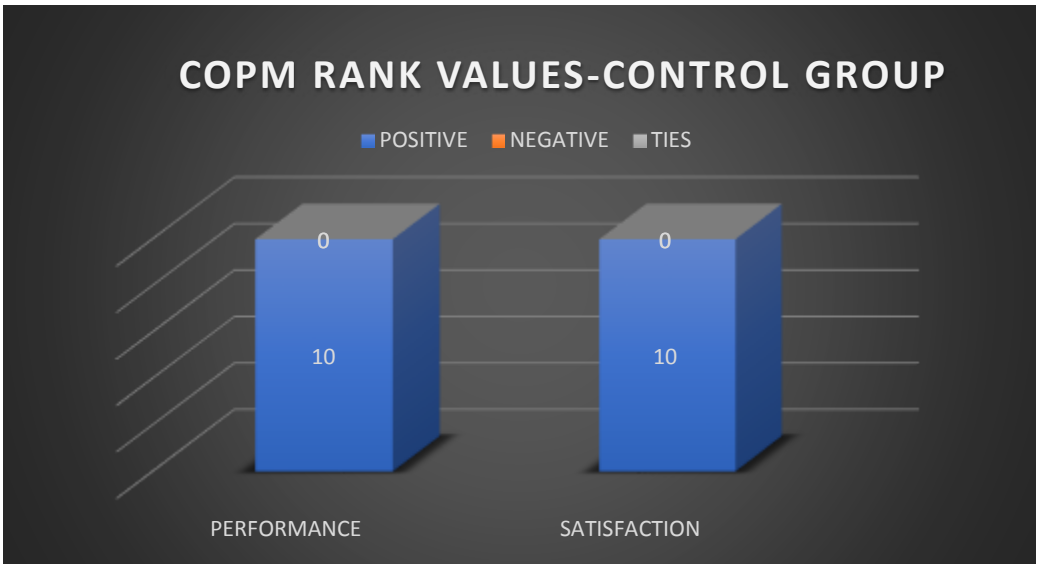
Table 4.2 shows that there was statistically significant difference **(p<.005)** between the pretest and posttest scores of performance and satisfaction components which means that control group has showed an improvement following intervention period.

GRAPH 4.2:



The above graph illustrates the same of table 4.2 with mean values indicating that the scores of posttest showing an improvement post intervention.

GRAPH 4.2a



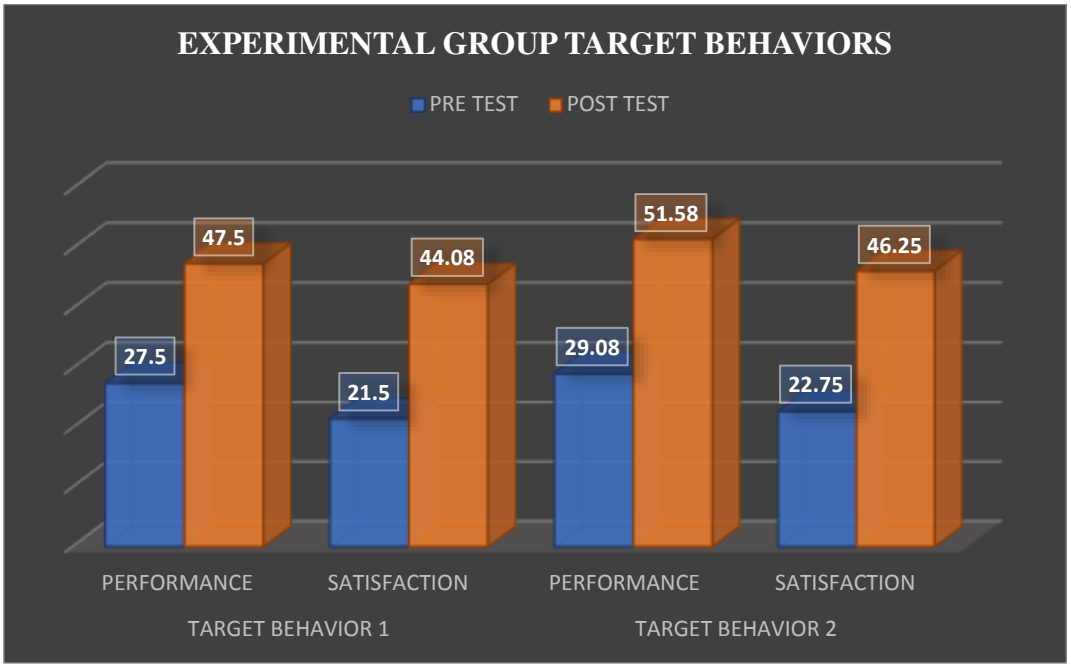
In the above graph, positive ranks indicate high scores of posttest and negative rank indicates high scores of pretest. Hence this shows that control group has improved in performance and satisfaction components in all subjects following intervention period.

TABLE 4.3: COMPARISON OF PRE-TEST AND POST TEST SCORES OF TARGET BEHAVIORS PERFORMANCE AND SATISFACTION IN EXPERIMENTAL GROUP [N=12]

VARIABLES		RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig P Value
POST-PRE							
Target Behavior 1	**Performance**	Negative Ranks	0	.00	.00	-3.07	**.002**
		Positive Ranks	12	6.50	78.00		
		Ties	0				
	Satisfaction	Negative Ranks	0	.00	.00	-3.06	**.002**
		Positive Ranks	12	6.50	78.00		
		Ties	0				
Target Behavior 2	**Performance**	Negative Ranks	0	.00	.00	-2.95	**.003**
		Positive Ranks	11	6.00	66.00		
		Ties	1				
	Satisfaction	Negative Ranks	0	.00	.00	-3.06	**.002**
		Positive Ranks	12	6.50	78.00		
		Ties	0				

Table 4.3 compares the post and pre-test scores of performance and satisfaction of target behavior 1and 2 of experimental group. The results display a statistical significant difference in both performance and satisfaction of targeted behaviors. **(p<.005).**

GRAPH 4.3



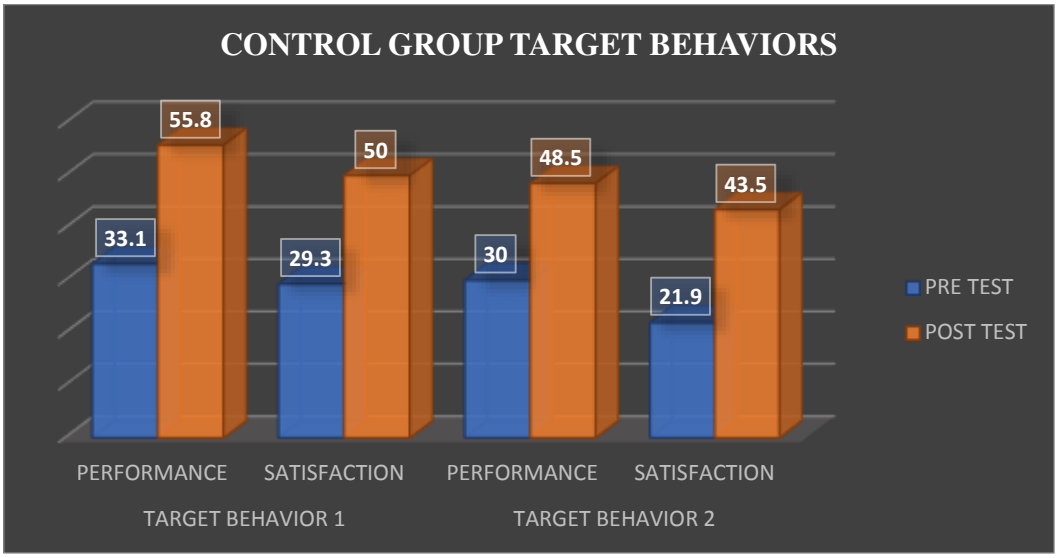
Graph 4.3 Illustrates the comparison mean values of performance and satisfaction for two target behaviors of experimental group showing improvement post intervention.

TABLE 4.4: COMPARISON OF PRE-TEST AND POST TEST SCORES OF TARGET BEHAVIORS PERFORMANCE AND SATISFACTION IN CONTROL GROUP [N=10]

VARIABLES		RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig p value
POST - PRE							
Target Behavior 1	Performance	Negative Ranks	0	.00	.00	-2.81	**.005**
		Positive Ranks	10	5.50	55.00		
		Ties	0				
	Satisfaction	Negative Ranks	0	.00	.00	-2.82	**.005**
		Positive Ranks	10	5.50	55.00		
		Ties	0				
Target Behavior 2	Performance	Negative Ranks	0	.00	.00	-2.81	**.005**
		Positive Ranks	10	5.50	55.00		
		Ties	0				
	Satisfaction	Negative Ranks	0	.00	.00	-2.81	**.005**
		Positive Ranks	10	5.50	55.00		
		Ties	0				

Table 4.4 shows that there was statistically significant difference **(p□.05)** between the pretest and posttest scores of performance and satisfaction components in both target behaviors showing that control group improved in posttest.

GRAPH 4.4



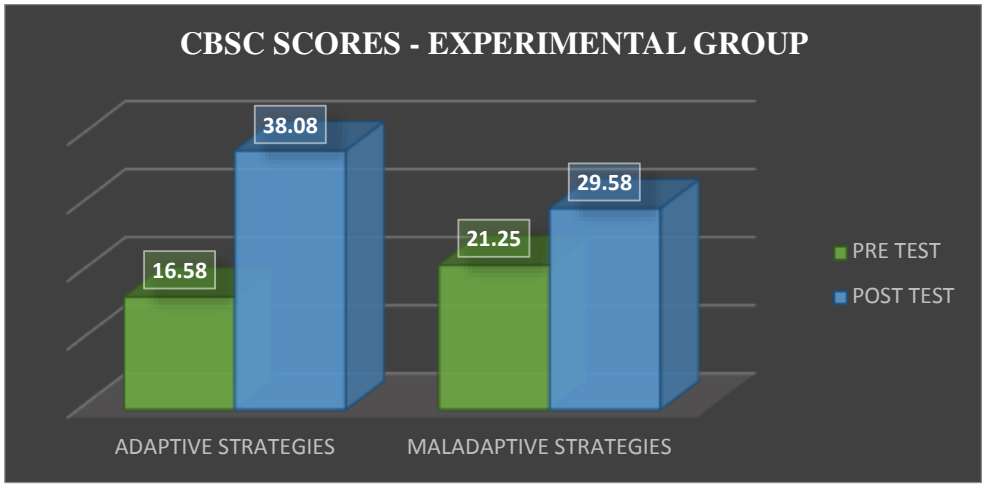
The above graph illustrates the mean values of COPM components showing improvement post intervention

TABLE 5.1: COMPARISON OF PRE-TEST AND POST TEST SCORES OF CBSC COMPONENTS IN EXPERIMENTAL GROUP [N=12]

VARIABLES POST - PRE	RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig p value
Adaptive Strategies	Negative Ranks	0	.00	.00	-3.07	**.002**
	Positive Ranks	12	6.50	78.00		
	Ties	0				
Maladaptive Strategies	Negative Ranks	1	3.00	3.00	-2.82	**.005**
	Positive Ranks	11	6.82	75.00		
	Ties	0				
Total Score	Negative Ranks	0	.00	.00	-3.06	**.002**
	Positive Ranks	12	6.50	78.00		
	Ties	0				

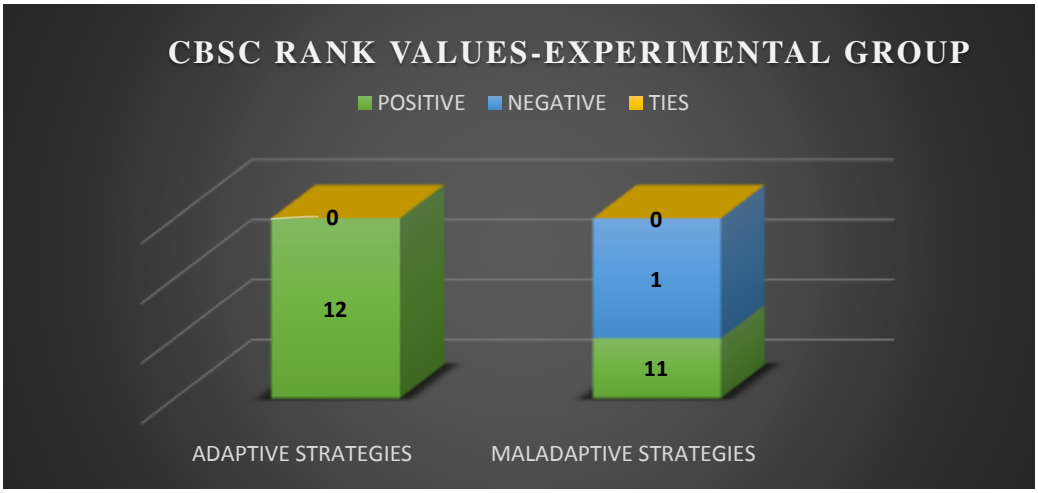
From the above table 5.1 results shows a significant difference in use of adaptive strategies **(p-.002)**, reduction in the usage of maladaptive strategies **(p-.005)** and significance in total scores **(p-.005).**

GRAPH 5.1



The above graph 5.1 illustrates the comparison of mean values of pretest and post test scores indicating the scores of posttest showing improvement in adaptive strategies and for maladaptive strategies reverse scoring is used showing higher values means minimal use of maladaptive strategies post intervention.

GRAPH 5.1a:



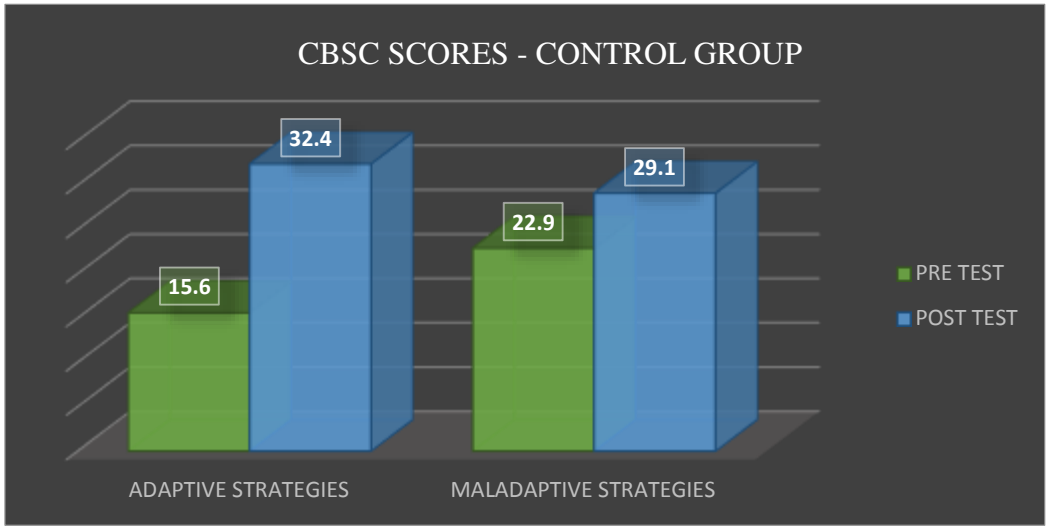
From the graph 5.1a positive ranks indicates high scores of children using adaptive strategies, this explains that post test scores were higher than the pre-test scores for adaptive strategies and there was an improvement in the experimental group after the intervention period. Negative rank indicate that one child did not improve post intervention and remaining children used minimal maladaptive strategies post intervention.

TABLE 5.2: COMPARISON OF PRE-TEST AND POST TEST SCORES OF CBSC COMPONENTS IN CONTROL GROUP [N=10]

VARIABLES POST - PRE	RANKS	N	MEAN RANK	SUM OF RANKS	Z value	Sig p value
Adaptive Strategies	Negative Ranks	0	.00	.00	-2.80	**.005**
	Positive Ranks	10	5.50	55.00		
	Ties	0				
Maladaptive Strategies	Negative Ranks	0	.00	.00	-2.80	**.005**
	Positive Ranks	10	5.50	55.00		
	Ties	0				
Total Score	Negative Ranks	0	.00	.00	-2.80	**.005**
	Positive Ranks	10	5.50	55.00		
	Ties	0				

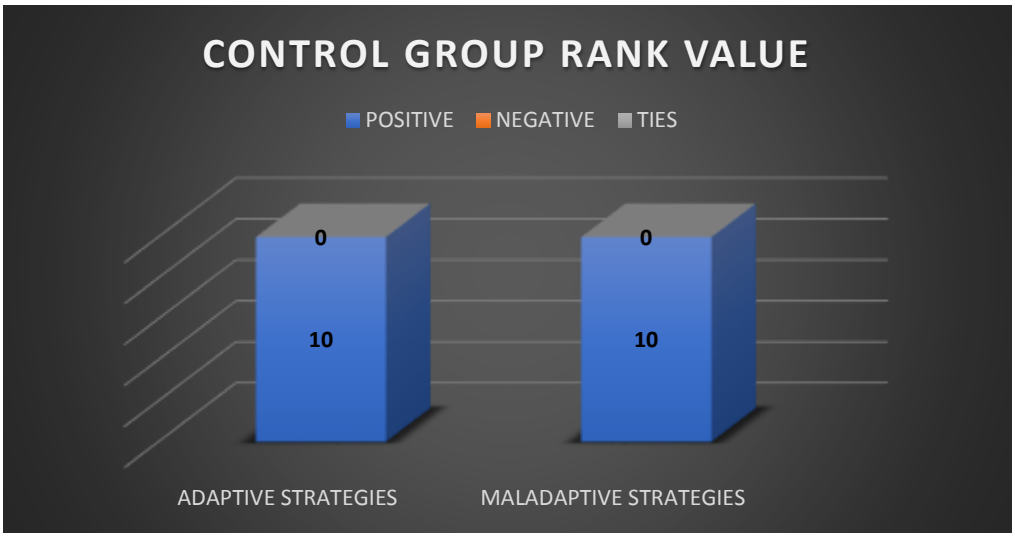
This table 5.2 shows that there was a significant difference **(p<.005)** in adaptive strategies, maladaptive strategies and in total scores.

GRAPH 5.2



The above graph illustrates the same of table 5.2 with mean values indicating that the scores of posttest showing an improvement in adaptive strategies and reduced use of maladaptive strategies post intervention.

GRAPH 5.2a



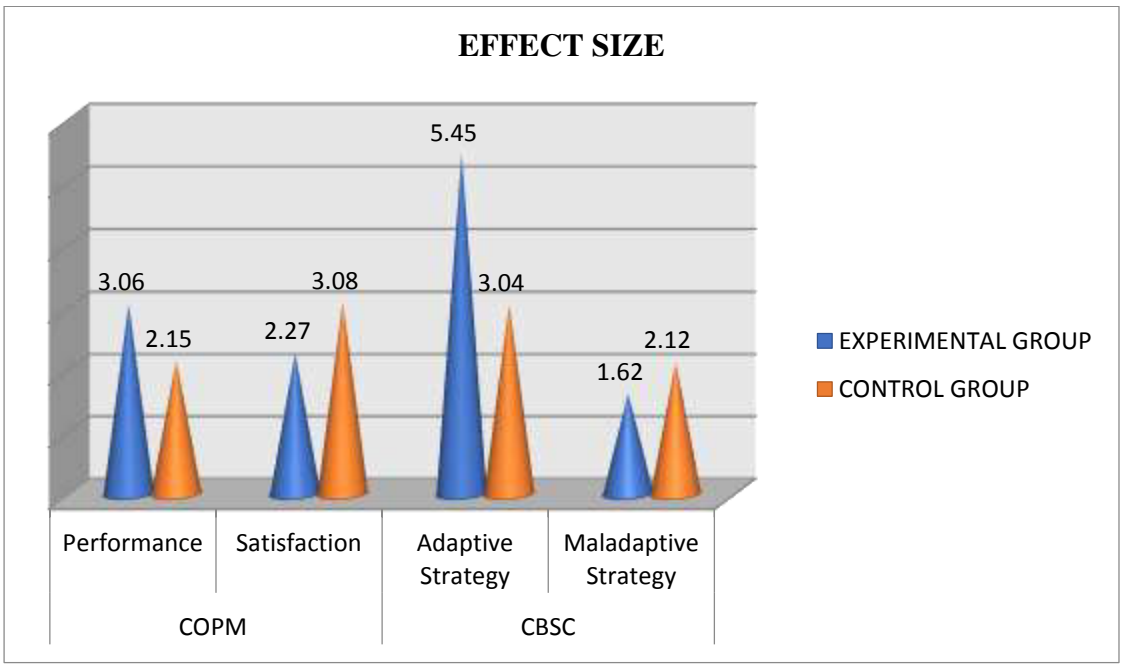
Graph 5.2a shows the positive ranks to be higher indicating children using Adaptive strategies, post intervention period and negative rank did not indicate lower scores in Maladaptive strategies which means children were using maladaptive strategies even after intervention period.

Table 6.1: COMPARISON OF EFFECT SIZE IN EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE		EXPERIMENTAL GROUP	CONTROL GROUP
COPM	**Performance**	**3.06**	2.15
	Satisfaction	2.27	**3.08**
CBSC	**Adaptive Strategy**	**5.45**	3.04
	Maladaptive Strategy	1.62	**2.12**

Both the groups show greater effect size (ES>1.00) from the above table. On comparing, experimental group showed higher values in performance and in adaptive strategies indicating children used more of adaptive strategies in their coping performance.

GRAPH 6.1



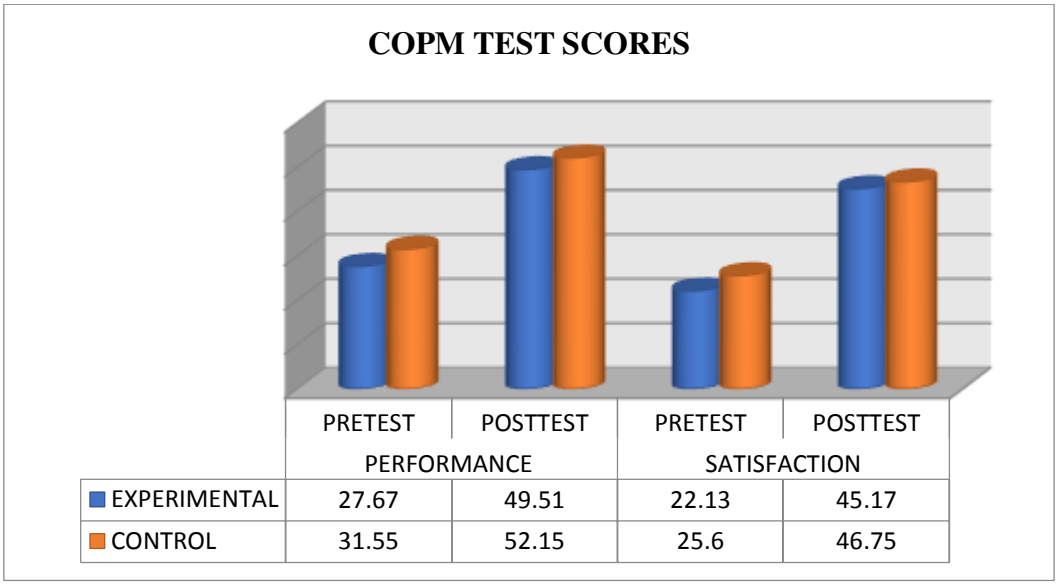
The above graph illustrates the values of effect size indicating experimental group showing grater values in performance and adaptive component, whereas satisfaction and maladaptive strategies displaying higher effect size in control group.

TABLE 7.1: COMPARISON OF COPM TEST SCORES BETWEEN THE EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE		GROUPS	N	MEAN RANK	SUM OF RANKS	Z Value	Sig p value
Pretest	**Performance**	Experimental	12	11.25	135.00	-.206	.837
		Control	10	11.80	118.00		
	Satisfaction	Experimental	12	9.50	114.00	-.971	.332
		Control	10	13.90	139.00		
Posttest	**Performance**	Experimental	12	10.29	123.50	-1.63	.102
		Control	10	12.95	129.50		
	Satisfaction	Experimental	12	10.29	123.50	-.975	-330
		Control	10	12.95	129.50		

The above table shows that there is no significant difference (p□0.05) in the pretest and post test scores of performance and satisfaction components of the experimental group and of the control group.

GRAPH 7



The above graph displays the mean values of performance and satisfaction component between experimental group and control group comparing its pretest and post test score.

TABLE 7.2: COMPARISON OF 1ST TARGET BEHAVIOR PERFORMANCE AND SATISFACTION SCORES BETWEEN THE EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE		GROUPS	N	MEAN RANK	SUM OF RANKS	Z Value	Sig p value
Pretest	**Performance**	Experimental	12	10.54	126.50	-.766	.443
		Control	10	12.65	126.50		
	Satisfaction	Experimental	12	8.29	99.50	-2.58	**.010**
		Control	10	15.35	153.50		
Posttest	**Performance**	Experimental	12	9.54	114.50	-1.56	.118
		Control	10	13.85	138.50		
	Satisfaction	Experimental	12	10.63	127.50	-.697	.486
		Control	10	12.55	125.50		

From the above table there is no significant difference seen in performance component and posttest values of satisfaction component. But from pretest values, satisfaction component shows significant difference [p<.010] indicating that children were satisfied with maladaptive strategy before intervention.

TABLE 7.3: COMPARISON OF 2ND TARGET BEHAVIOR PERFORMANCE AND SATISFACTION SCORES BETWEEN THE EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE		GROUPS	N	MEAN RANK	SUM OF RANKS	Z Value	Sig p value
Pretest	**Performance**	Experimental	12	12.12	145.50	-.499	.618
		Control	10	10.75	107.50		
	Satisfaction	Experimental	12	12.13	145.50	-.503	.615
		Control	10	10.75	107.50		
Posttest	**Performance**	Experimental	12	12.33	148.00	-.667	.505
		Control	10	10.50	105.00		
	Satisfaction	Experimental	12	11.67	140.00	-.133	.894
		Control	10	11.30	113.00		

The above tables 7.2 and 7.3 compares the pre-test and post test scores between the groups for performance and satisfaction components for two target behaviors, scores indicate that the groups are not significantly different.

TABLE 8.1: COMPARISON OF CBSC COMPONENTS PRE TEST SCORES BETWEEN THE EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE PRETEST	GROUPS	N	MEAN RANK	SUM OF RANKS	Z Value	Sig p value
Adaptive Strategies	Experimental	12	12.17	146.00	-.530	.596
	Control	10	10.70	107.00		
Maladaptive Strategies	Experimental	12	10.96	131.50	-.430	.667
	Control	10	12.15	121.50		
Total Score	Experimental	12	11.63	139.50	-.099	.921
	Control	10	11.35	113.50		

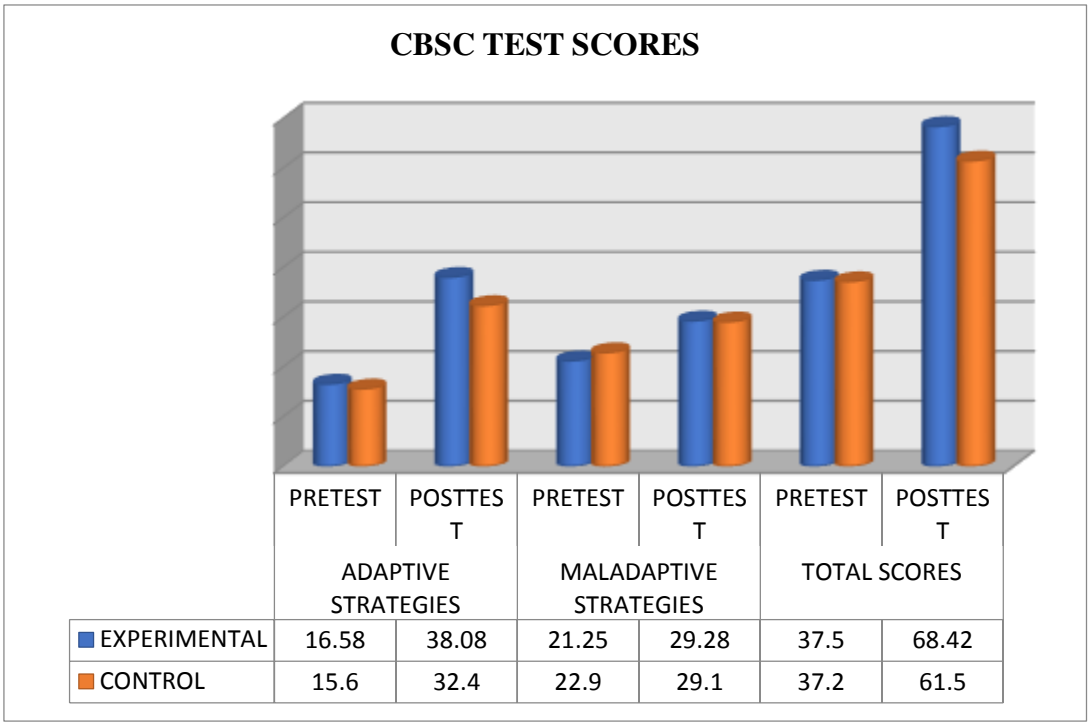
Table 8.1 shows that there is no significant difference (p□0.05) in the pretest scores of CBSC components and its total between both experimental group and the control group.

TABLE 8.2: COMPARISON OF CBSC COMPONENTS POST TEST SCORES BETWEEN THE EXPERIMENTAL GROUP AND CONTROL GROUP

VARIABLE POSTTEST	GROUPS	N	MEAN RANK	SUM OF RANKS	Z Value	Sig p value
Adaptive Strategies	Experimental	12	14.38	172.50	-2.297	**.022**
	Control	10	8.05	80.50		
Maladaptive Strategies	Experimental	12	13.08	157.00	-1.266	.206
	Control	10	9.60	96.00		
Total Score	Experimental	12	14.25	171.00	-2.180	**.029**
	Control	10	8.20	82.00		

The above table 8.2 shows that there was a statistically significant difference (p□.05) between the posttest scores of both the groups indicating that there was an improvement in the adaptive strategies and in overall use of coping strategies following intervention in experimental group.

GRAPH 8



Graph 8 illustrates the comparison of mean values of CBSC test scores between the experimental group and control group showing experimental group with higher mean values in posttest.

RESULTS

Tables 1 and 2 provide information on age, gender and children diagnosis respectively.

Table 3 shows the mean values of pre and posttest scores of Canadian Occupational Performance Measure [COPM] and Children with Bullying Scale for Children [CBSC] for both experimental group and control group.

RESULT OF ANALYSIS OF CANADIAN OCCUPATIONAL PERFORMANCE MEASURE COMPONENT

- Within group comparison of experimental group on Canadian Occupational Performance Measure [COPM] performance component shows a significant difference in the pre and posttest values **p = .002**, and on comparing with pre and post test scores of control group **p =.005.** It reveals that both the group showed significant difference indicating that both the groups have shown improvement. (table 4.1.4.2)
- Within group comparison of experimental group satisfaction component, results show that there is significant difference in the pre and posttest of experimental group **p=.003**, when comparing with pre and post test scores of control group **p=.005**. It reveals that both the group showed significant difference indicating that both the groups have shown improvement. (table 4.1.4.2)
- Within group comparison on performance and satisfaction components of 1st target behaviour of experimental group shows a significant difference in the pre and posttest values **p <.005** and control group showed **p <.005**. It reveals that both the group showed significant difference showing that both the groups have improved. (table 4.4)
- Within group comparison of performance and satisfaction components of 2nd target behaviour of control group shows a significant difference in the pre and posttest values **p<.005** and control group showed **p<.005**. It reveals that both the group showed significant difference. (table 4.4)

- Between group comparison of pretest and posttest shows that there is no significant difference **p>.005** in the experimental and control group on both performance and satisfaction component indicating homogeneity of groups prior to therapy, and at posttest level both the groups have equally improved. (table 7.1)
- Between group comparison of pretest and posttest of 1st target behavior scores show that there is no significant difference **p>.005** in the experimental and control group on performance component indicating homogeneity of groups prior to therapy and showed equal improvement post intervention. (table 7.3)
- Between group comparison of pretest satisfaction component of 1st target behavior scores showing a significant difference **p<.005** in the experimental and control group indicating children were satisfied with maladaptive strategy before intervention. (table 7.2)
- Between group comparison of posttest satisfaction component of 1st target behavior scores show that there is no significant difference **p>.005** in the experimental and control group indicating there was equal improvement post intervention. (table 7.2)
- Between group comparison of pretest and posttest of 2nd target behavior scores shows that there is no significant difference **p>.005** in the experimental and control group on both performance and satisfaction component indicating homogeneity of groups prior to therapy and showed equal improvement post intervention. (table 7.3)

RESULT OF ANALYSIS OF EFFECT SIZE FOR COPM COMPONENTS

Both the groups showed a greater effect size (ES>1.00)

- On comparing, experimental group showed higher values in performance component and control group showing higher values in satisfaction components. (table 6.1)

RESULT OF ANALYSIS OF COPING WITH BULLYING SCALE FOR CHILDREN [CBSC] COMPONENT

- Within group comparison of experimental group Children with Bullying Scale for Children [CBSC] adaptive strategy shows that there is significant difference in the pre and posttest of experimental group **p=.002**, when comparing with pre and post test scores of control group **p=.005**. It reveals that both the group showed significant difference. (table 5.1.5.2)
- Within group comparison of experimental group Children with Bullying Scale for Children [CBSC] maladaptive strategy shows that there is significant difference in the pre and posttest of experimental group **p=.005**, when comparing with pre and post test scores of control group **p=.005**. It reveals that both the group showed significant difference. (table 5.1.5.2)
- Within group comparison of experimental group Total scores in CBSC adaptive shows that there is significant difference in the pre and posttest of experimental group **p=.002**, and pre and post test scores of control group **p=.005**. It reveals that both the group showed significant difference. (table 5.1.5.2)
- Between group comparison of pretest scores shows that there is no significant difference **p>.005** in the experimental and control group on all components that is adaptive, maladaptive strategies and total scores. (table 8.1)
- Between group comparison of posttest shows that there is a significant difference **p<.022** in the experimental and control group on adaptive strategies indicating improvement seen post intervention. (table 8.2)
- Between group comparison of posttest shows that there is a significant difference **p<.206** in the experimental and control group on maladaptive strategies indicating children in both the group used maladaptive strategies even after Social story and coping strategy intervention. (table 8.2)
- Between group comparison of posttest shows that there is a significant difference **p<.029** in the experimental and control group on adaptive strategies indicating improvement seen in total scores post intervention. (table 8.2)

RESULT OF ANALYSIS OF EFFECT SIZE ON CBSC COMPONENTS

Both the groups showed a greater effect size (ES>1.00)

- On comparing, experimental group showed higher values in adaptive strategies indicating children used more of adaptive strategies in their coping performance and control group showing higher values in maladaptive strategies. (table 6.1)

DISCUSSION

This study was conducted in and around Coimbatore, samples were selected from Occupational therapy department at Kovai Medical Centre and Hospital and from St. John's Matric.Hr. Sec.School. The aim of the study was to determine the effectiveness of Social Stories in improving coping skills for Bullying among childhood psychiatric conditions.

All the parents willingly provided their written consent. Children were screened through Illinois bully victim scale and twenty-two children with childhood psychiatric conditions were enrolled for the study according to the determined selection criteria. Children with high scores of victims' subscale were divided into Control Group and Experimental Group. All the children were undergoing occupational therapy regularly. In experimental group out of 12 children 11 were receiving special education for academics in integrated school and 1 child was going to regular school. In control group out of 10 children 4 children were going to regular school and 6 children were getting special education in integrated school.

Higher rates of being bullied and increased risk for being victimized have been reported in children with LD, ADHD and Learning disabilities.[20] In the current study participants belonged to the same children diagnosed as LD, ADHD and Mild ID.

A case series study[16] indicates that within ten days LD& ADHD children could comprehend answers to about social stories with 100% accuracy. Experimental group children received individual Social Story sessions for half an hour, two/three days a week followed by Role play and control group were given with individual Coping Strategies sessions for half an hour, two/three days a week followed by Role play.

Considering to another point that, if a child is victimized he/she should be provided with guidance about how they can learn from the past coping responses to prepare for the future. Hence in the present study role play given at the end of social story sessions enhancing the use of adaptive strategies as therapist discussed about hypothetical bullying situation and how well the child could use positive responses in dealing with bullying situation.

Initially bullying was looked onto from psychological and family pathology but currently it is being considered in terms of sociological aspects where bullying is used to attain social status in the school network hierarchy, with weak and vulnerable populations comprising 'easy targets' and being a 'victim'. So, disabled children are often regarded among vulnerable groups, occupying marginal positions in school settings.[21]

These children often show lack of social skills and in understanding social situations leading them to be at risk for bullying. Researchers from a study[12] recommends that these children must be provided social skill training that focuses on avoiding bullying situations and coping with the aftermath of bullying when it occurs.

Hence considering the need for individualized intervention for understanding of social situation, Social Story was primarily preferred. Being individualized, social story build on child's experiences and prior knowledge in helping them to extend their ideas in reality. Ultimately the purpose of a social story was to provide children a greater understanding of social situations and their circumstances surrounding a targeted social situation. According to the revised guidelines social stories can also be presented as booklets with pictures[22], which was adapted in the present study.

Researchers[3,20] identified name-calling as the most common form of bullying and it can be one of the most distressing teasing behaviors that children find difficult to cope with, and adults often underestimate its damaging effects. Simon's story in the current study was prepared to aid in understanding of situation where children usually were called with names describe the adequate responses like 'not reacting to bully, moving away from that place to the children.

Similarly, another pattern of bullying observed in children are ganging up & striking, pushing and punching which is also estimated to happen more likely. In the current study, similar pattern of bullying was identified in the subject also. Tony's story was presented to the children for addressing the above bullying situation and adaptive coping strategies were taught with the help of Social stories.

COPM was administered to the children for obtaining their target behaviors that is the bullying situation the child encountered. Followed by which Coping with bullying

scale for children [CBSC] is administered to determine whether the children used Adaptive or Maladaptive Coping strategies. Researchers suggest that disabled Children used mal adaptive coping strategies such as yelling the bullying back, victim thinking that they deserve it, physically attack the bully back, etc. more than the adaptive strategies in response to being victimized.[13]

In this study the effectiveness of Social stories was analyzed by how well the child was dealing with bulling situation (COPM- performance), how much satisfied (COPM - satisfaction) they were on handling the situation and their use of adaptive and maladaptive strategies.

EFFECT OF SOCIAL STORY ON COPING PERFORMANCE

According to researchers[34] Social stories used as an instructional strategy will improve skills of children with wide range of disabilities and also demonstrated it can increase appropriate behavior in children. On analyzing both performance and satisfaction levels of children, results showed an improvement in experimental group (table 4.1) indicating that Social story intervention program have helped children to perform during bullying situation.

Children in intervention group showed more improvement in adaptive coping strategies than control group. (table 8.2). Social stories have helped children to learn adaptive strategies and enabled application of learnt coping skills.

Effect size in experimental group showed greater effect (table 6.1) showed greater effect. Study[16] suggested that children were able to perform well at the end of social stories sessions and they could share some of their meaning and demonstrate comprehension therefore indicating that children used adaptive strategies in social stories for dealing with bullying situation.

EFFECT OF VERBAL TEACHING ON COPING PERFORMANCE

A Study by Dorothy L Espelage, Rose A, and Polanin J R[24] suggested that by providing direct instructions in the areas of self-awareness, social awareness, self-management, problem solving and relationship management reduced a bullying, victimization, and fighting among students with disabilities. In the current study

children who receive verbal teaching on coping strategies also improved relatively (table 6.1)

According to Multidimensional model for coping with bullying[25] it is suggested that if children are provided with adequate teaching methods they will respond in a positive way for handling a bullying situation. This is consistent with the results of control group which showed a larger effect size (ES=3.04) indicating that verbal teaching was also helpful for children for using adaptive coping styles.

COMPARISON OF INTERVENTION

Between group comparison of COPM revealed that both groups equally improved with their respective intervention. However, on comparing the mean difference for experimental and control group (21.87,20.6 respectively) indicates a slightly higher effectiveness of social stories.

On comparing the mean values of adaptive coping strategies of experimental group and control group (38.08,32.40 respectively) results suggest that children in experimental group performed (using adaptive responses) higher than control group (table 3.1)

Further on comparing the total scores of Coping with bullying scale for children[CBSC] of experimental and control group (68.42,61.50) it is inferred that children intervened with Social stories improved in using more of adaptive coping strategies.

According to research [20] it is apparent that the children enjoyed the social story sessions and speculated that the effects of repeatedly read social stories create long-term effects on a child's behavior and with continued monitoring for its effectiveness with each child.[34] Thus social story enabled children in learning adaptive coping strategy had greater impact in performing while dealing a bullying situation.

Both the group some amount of maladaptive strategies even after their respective interventions. This reveals that the intervention (Social stories) did not reduce the use of maladaptive coping strategies.

Social stories used for a long duration may reduce the use of maladaptive strategies while increasing coping strategies. Researchers on reviewing the result of a study[14] suggested that children with recent experience of victimization are more likely to respond in maladaptive way of coping.

According to meta-analysis study[34] conducted on social stories it is also suggested that Social stories improve social skills rather than decreasing inappropriate behavior. In the present study social stories prepared were not used to address maladaptive coping styles. Thus Social story was found to have an impact only on the children's adaptive coping responses and was helpful in learning and using adaptive coping strategies in dealing with bullying situations.

However, on analyzing the satisfaction components of COPM it revealed that the children in both groups were satisfied on their performance, irrespective of their adaptive or maladaptive strategies. This warrants the importance of addressing on the awareness of adverse consequences of using maladaptive strategies through social stories.

CONCLUSION

From the study it can be concluded that,

- Social stories are effective in improving coping skills for bullying among children with childhood psychiatric conditions
- Social stories enabled application of learnt coping skills (performance) during bullying situation.
- Social stories did not reduce maladaptive skills adequately.
- Verbal teaching of coping skill also was effective in coping with bullying situation.
- Social stories had slightly greater impact on coping skills than verbal teaching.

LIMITATIONS AND RECOMMENDATION

LIMITATIONS:

- Children who were victims of bullying were only considered irrespective of them to be either bullies or bystanders.
- Duration of exposure to bullying was not considered.
- The duration of Social Stories and Coping strategies session were limited and only two target behaviors were focused.
- Unawareness of parents/ teachers about the importance of addressing bullying situation was not considered.
- Generalization of study results are limited because of small sample size.

RECOMMENDATIONS:

- Studies should focus on children who are both bullies and victims in bullying situations.
- Social stories can be used for children to identify and reduce maladaptive coping strategy to deal with bullying.
- Social stories sessions can be increased in order to determine the long term effects of bullying.
- Follow up should be done for modifying or changing Social Stories as the child learns.

REFERENCES

1. Rigby K., Bauman S. *What teachers think should be done about cases of bullying. Professional Educator. Melbourne: Australian Council for Educational Research.* (2007).
2. Olweus D. *Bullying at school: What we know and what we can do.* Cambridge, MA: Blackwell.: (1993).
3. Srisiva R, Thirumoorthi R, Sujatha P. Prevalence and Prevention of School Bullying - A Case Study of Coimbatore City. *International Journal of Humanities and Social Science Invention* (2013); Vol.2 (5) (2319 – 7714)
4. Rose, C. A., & Monda-Amaya, L. E. Bullying and victimization among students with disabilities: Effective strategies for classroom teachers. Intervention in School and Clinic. 2011; 48.
5. Hymel S, Swearer S M. Four Decades of Research on School Bullying. *American Psychological Association* (2015); Vol. 70, No. 4, (dx doi.org / 10. 1037 / a0038928)
6. Fekkes, M., Pijpers, F. I. M., & Vereloove-Vanhorick, S. P. Bullying: Who does what, when and where? Involvement of children, teachers and parents in bullying behavior. *Health Education Research,* (2005).; 20.
7. Rose, C. A., Monda-Amaya, L. E., & Espelage, D. L. Bullying perpetration and victimization in special education: A review of the literature. *Remedial and Special Education,* (2011); 32, (doi:10.1177/0741932510361247)
8. Pampel F. Bullying and Disability: An Overview of the Research Literature. *Colorado Developmental Disabilities Council.* (2013)
9. Rose C A, Espelage D L, Monda L A, Shogren K A, and Steven R. Aragon. Bullying and Middle School Students with and Without Specific Learning Disabilities: An Examination of Social-Ecological Predictors. *Journal of Learning Disabilities.* (2013); XX(X) (doi: 10.1177/0022219413496279)
10. Jenson, J. M., & Dieterich, W. A., Effects of a skills-based prevention program on bullying and bully victimization among elementary school children. *Prevention Science* (2007).; 8, (285-296.)

11. Glumbi N, Zuni-Pavlovi V. Bullying behavior in children with intellectual disability. *Procedia Social and Behavioral Sciences* (2010); 2(doi: 10.1016 / j.sbs pro.20 10.03.415)
12. Pelchar, Kaine T. Bullying, Victimization, Associated Distress & Transition Among Intellectually Gifted Children. (2011)
13. Preventing school bullying of children with Special Educational Needs or Disability. *National Disability Authority* (2014)
14. Donoghu C, Almeida A, Brandwein D, Rocha G, Callahan I. Coping with Verbal and Social Bullying in Middle School. *The International Journal of Special Education* (2014); Vol: 6(2) (2073-7629,)
15. Reynhout G, Mark Carter. Social Stories for Children with Disabilities. *Journal of Autism and Developmental Disorders,* (2006); Vol. 36(4), (doi 10.1007/s10803-006-008 6-1)
16. Eckelberry E. Using Social Stories with Children with Autism, Learning Disabilities and ADHD. *Department of Teacher Education.* (2007)
17. Naniwadekar K, Malar. G, Kumar H, Suresh A.E.G. Typically Developing children in Indian mainstream classrooms: Buddies or Bullies of Children with Special Needs. *International Journal of Education and Psychological Research (IJEPR),* (2013); Volume2, Issue4(ISSN:2279-0179)
18. Malian, I. M. Bully versus Bullied: A Qualitative Study of Students with Disabilities in Inclusive Settings. *Electronic Journal for Inclusive Education* (2012).;2(10)
19. Rose, C. A., & Espelage, D. L. Risk and protective factors associated with the bullying involvement of students with emotional and behavioral disorders. (2012).; 37(3).
20. Carter B.B, Vicky G. Spencer. The Fear Factor: Bullying and Students with Disabilities. *International journal of special education.* (2006)
21. Chatzitheochari S, Samantha Parsons, Lucinda Platt. Doubly Disadvantaged? Bullying Experiences among Disabled Children and Young People in England. *Sociology* (2016); Vol. 50(4) (DOI: 10.1177/0038038515574813)
22. Carlson E J, Flannery M C, Kral M S. Differences in Bully/Victim Problems between Early Adolescents with Learning Disabilities and their Non-Disabled Peers. (2005)

23. Fekkes M, Pijpers F I M, Fredriks M, Vogels T, Verloove-Vanhorick S P. Do Bullied Children Get Ill, or Do Ill Children Get Bullied? A Prospective Cohort Study on the Relationship Between Bullying and Health-Related Symptoms. *Journal of the American Academy of Paediatrics,* (2006); 117;(doi: 10.1542/peds.2005-0187)
24. Espelage D L, Rose C A, and, Polanin R. Social-Emotional Learning Program to Reduce Bullying, Fighting, and Victimization Among Middle School Students with Disabilities. *Remedial and Special Education,* (2015); (doi:10.1177 /0741932514564564.):
25. Parris, Leandra N. The Development and Application of the Coping with Bullying Scale for Children. *Counselling and Psychological services. Scholar works.* (2013) ;(gsu.edu/cpsdiss/93)
26. Hardin E C. Are Social Stories an Effective Intervention Method for Children Diagnosed with Autism Spectrum Disorders and Related Developmental Disorders. *School of Education.* (2015)
27. Goncalves L, Voos M C, Helena M, Morgani de Almeida, and Caromano F A. Massage and Storytelling Reduce Aggression and Improve Academic Performance in Children Attending Elementary School. *Occupational Therapy International* (2017); Vol, 5087145, (doi.org/10.1155/2017/5087145)
28. Gray, C. The New Social Story Book. (2000).
29. Saia D.M, Saylor C.F, Allen R.A, Arnau P.L. Bullying experiences, anxiety about Bullying, and special education placement *JAASEP* (2009)
30. Polasky. S. A Dissertation Coping with School Bullying: An Examination of Longitudinal Effects of Coping on Peer Victimization and Adjustment (2010)
31. Gray. C and Jonker. S. Gray guide to Bullying*, Jenison autism journal creative ideas in practice*; Vol 16 (1) (2004)
32. Swaggart, B. L., Gagnon, E., Bock, S. J., Earles, T. L., Quinn, C., Myles, B. S., & Simpson, R. Focus on Autistic Behavior. Using social stories to teach social and behavioral skills to children with autism. *Focus on Autistic Behavior,* (1995); 10(1)
33. Davenport. N. R. A comparative study of stress and coping skills among learning disabled and regular education students, *Retrospective Theses and Dissertations.* (1991); (9931.)

34. David W. Test, Richter S, Knight V, Spooner F. A Comprehensive Review and Meta-Analysis of the Social Stories Literature. Focus on Autism and Other Developmental Disabilities (2011) ;26(1) (DOI: 10.1177/1088357609351573):
35. American occupational therapy association [AOTA]. Occupational Therapy's Role in Mental Health Promotion, Bullying Prevention and Friendship Promotion. Information sheet. *School Mental Health Toolkit American occupational therapy association [AOTA]* (2013)
36. Lerner M D, White S W, McPartland. Mechanisms of change in psychosocial interventions for autism spectrum disorders (2012); Vol 14, (307-318).

APPENDIX I

TARGETED BEHAVIOURS IN CHILDREN - EXPERIMENTAL GROUP

S.NO	CHILDREN	TARGETED BEHAVIOURS
1.	Subject 1	▪ Calling me bad names, 'short, lean girl' ▪ Hitting purposefully
2.	Subject 2	▪ Calling me like 'omlette, beggar, hyper, pig' ▪ Hitting for simply
3.	Subject 3	▪ Calling with funny names ▪ Pushing, hitting me in playground and hostel
4.	Subject 4	▪ Teasing me and about my family members ▪ Hitting and asking me to come for fight
5.	Subject 5	▪ Calling me like 'beggar, mental, hyper ▪ Hitting me
6.	Subject 6	▪ Calling me like 'girl, loose, hyper' ▪ Hitting, fighting with me
7.	Subject 7	▪ Calling names ▪ Hitting me
8.	Subject 8	▪ Calling me 'naughty, bad boy' ▪ Hitting me, so hitting them back
9.	Subject 9	▪ Calling me 'sodabutti, loose' ▪ Knocking my head pushing me in playground
10.	Subject 10	▪ Calling me with funny names ▪ Hitting me and fighting with me
11.	Subject 11	▪ Calling me 'liar, blaming me for theft' ▪ Hitting me purposefully
12.	Subject 12	▪ Calling me bad names ▪ Beating me in hostel

APPENDIX II

TARGETED BEHAVIOURS IN CHILDREN – CONTROL GROUP

S.NO	CHILDREN	TARGETED BEHAVIOURS
1.	Subject 1	▪ Calling names with bad names ▪ Beating me in hostel
2.	Subject 2	▪ Calling with funny names ▪ Beating and pushing me
3.	Subject 3	▪ Calling me and frightening me ▪ Pushing, hitting me in playground and hostel
4.	Subject 4	▪ Calling mw like 'hyper, loose, mental' ▪ Hitting me in class
5.	Subject 5	▪ Calling me like 'beggar, mental, hyper ▪ Fighting with me in hostel and hitting me
6.	Subject 6	▪ Calling me with bad names and so I am also calling them ▪ Hitting, pushing, making to fight with them
7.	Subject 7	▪ Calling names ▪ Hitting me
8.	Subject 8	▪ Calling me 'naughty, bad boy', irritating during class ▪ Hitting me when I don't bring them after bet
9.	Subject 9	▪ Calling, singing funny names ▪ Hitting, pushing and blaming me for no reasons
10.	Subject 10	▪ Calling me and hiding. Ignoring me while playing ▪ Hitting and pushing me purposefully

APPENDIX III

PARENTAL CONSENT FORM

I Mr / Mrs/ Miss _____ as a parent/legal guardian, authorize _____ (child name) to become a participant in the research study: “Effectiveness of social stories for children with childhood psychiatry conditions in coping with bullying”. The researcher has explained me the content of her research in brief, what she needs to interview from, what treatment program she is providing and has answered the questions related to the research to my satisfaction.

Date:

Signature of the parent/Guardian:

Signature of the Researcher:

APPENDIX IV

ILLINOIS BULLY-VICTIM SCALE
(Dorothy L. Espelage & & Holt, 2001)

DATE: _____

NAME: _____ **AGE:** _____

SCHOOL: _____ **GRADE:** _____

FOR EACH OF THE FOLLOWING QUESTIONS, CHOOSE HOW MANY TIMES YOU DID THIS ACTIVITY OR HOW MANY TIMES THESE THINGS HAPPENED TO YOU IN THE LAST 30 DAYS

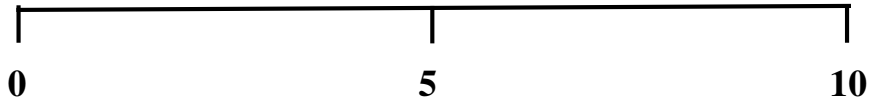
S.NO	QUESTIONS	Never (0)	1 or 2 Times (1)	3 or 4 Times (2)	5 or 6 Times (3)	7 or more Times (4)
1	I upset other students for the fun of it.					
2	In a group I teased other students.					
3	I fought students I could easily beat.					
4	Other students picked on me.					
5	Other students made fun of me.					
6	Other students called me names.					
7	I got hit and pushed by other students.					
8	I helped harass other students.					
9	I teased other students.					
10	I got in a physical fight.					
11	I threatened to hurt or hit another student.					
12	I got into a physical fight because I was angry.					
13	I hit back when someone hit me first.					
14	I was mean to someone when I was angry.					
15	I spread rumors about other students.					
16	I started (instigated) arguments or conflicts.					
17	I encouraged people to fight.					
18	I excluded other students from my clique of friends.					

APPENDIX V

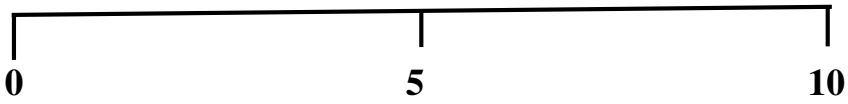
CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

S.NO	TARGET BEHAVIOURS	IMPORTANCE	PERFORMANCE	SATISFACTION

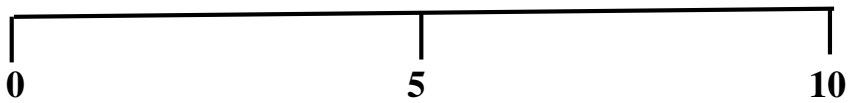
IMPORTANCE



PERFORMANCE



SATISFACTION



APPENDIX VI

COPING WITH BULLYING SCALE FOR CHILDREN (CBSC)

(Parris, Varjas, Meyers, & Henrich, 2011)

NAME: AGE/GENDER: DATE:

S.NO	When YOU are picked on , how often DO YOU ...?	Almost Never	Some times	Often	Almost Always
1.	take deep breaths	**0**	**1**	**2**	**3**
2.	try to find a way to make the bully stop	**0**	**1**	**2**	**3**
3.	yell at the bully	**0**	**1**	**2**	**3**
4.	think of ways to solve the problem	**0**	**1**	**2**	**3**
5.	think you deserve it	**0**	**1**	**2**	**3**
6.	pretend you don't care	**0**	**1**	**2**	**3**
7.	avoid areas the bully goes to	**0**	**1**	**2**	**3**
8.	try to forget about it	**0**	**1**	**2**	**3**
9.	tell your parents	**0**	**1**	**2**	**3**
10.	think it's because of something you did	**0**	**1**	**2**	**3**
11.	lose your temper	**0**	**1**	**2**	**3**
12.	stay near adults so the bully won't bully you	**0**	**1**	**2**	**3**
13.	talk about how you feel with friends or family	**0**	**1**	**2**	**3**
14.	say something mean to the bully	**0**	**1**	**2**	**3**
15.	ignore the situation	**0**	**1**	**2**	**3**
16.	bully the person back	**0**	**1**	**2**	**3**
17.	go to a quiet place to calm down	**0**	**1**	**2**	**3**
18.	think it's not that bad	**0**	**1**	**2**	**3**
19.	physically attack the bully	**0**	**1**	**2**	**3**
20.	ignore the bully so he/she stops bullying you	**0**	**1**	**2**	**3**
21.	tell the teacher	**0**	**1**	**2**	**3**
22.	keep friends near you to keep the bully away	**0**	**1**	**2**	**3**
23.	make a plan of what to do about it	**0**	**1**	**2**	**3**
24.	blame yourself for what happened	**0**	**1**	**2**	**3**
25.	think about positive things in your life	**0**	**1**	**2**	**3**
26.	think it's your fault	**0**	**1**	**2**	**3**
27.	walk away from the bully so he/she stops	**0**	**1**	**2**	**3**
28.	keep it to yourself and not tell anyone	**0**	**1**	**2**	**3**
29.	count to 10	**0**	**1**	**2**	**3**
30.	think you should have done something to stop it	**0**	**1**	**2**	**3**

MASTER CHART

ILLINOIS BULLY VICTIM SCALE							
EXPERIMENTAL GROUP				CONTROL GROUP			
S.NO	BULLY SCALE	VICTIM SCALE	FIGHTING SCALE	S.NO	BULLY SCALE	VICTIM SCALE	FIGHTING SCALE
1	2	14	0	1	3	10	5
2	5	15	10	2	7	12	7
3	6	12	9	3	2	10	6
4	11	14	2	4	2	9	4
5	15	10	6	5	7	8	5
6	6	13	4	6	13	11	9
7	11	11	7	7	3	13	6
8	18	10	11	8	9	12	13
9	2	11	3	9	8	12	5
10	8	10	4	10	5	10	3
11	8	13	3				
12	6	10	4				

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE [COPM]									
EXPERIMENTAL GROUP					CONTROL GROUP				
S.NO	PRE IMPxPER	POST IMPxPER	PRE IMPxSAT	POST IMPxSAT	S.NO	PRE IMPxPER	POST IMPxPER	PRE IMPxSAT	POST IMPxSAT
1	21	47	20	39	1	47	60	26	47
2	34	60	30	77	2	20	39	23	35
3	39	40	26	52	3	26	60	17	51
4	38	51	26	40	4	26	51	30	47
5	20	39	13	33	5	37	59	33	59
6	21	56	17	51	6	47	60	34	43
7	30	55	26	47	7	43	60	22	60
8	24	40	16	24	8	24	44	24	40
9	26	47	22	34	9	23	40	19	41
10	34	55	26	50	10	26	51	30	47
11	30	55	26	55					
12	18	51	21	43					

EXPERIMENTAL GROUP						
S.NO	PRE ADAPTIVE STRATEGY	POST ADAPTIVE STRATEGY	PRE MALADAPTIVE STRATEGY	POST MALADAPTIVE STRATEGY	PRETOTAL	POST TOTAL
1	20	47	27	35	47	82
2	21	42	14	31	31	73
3	18	35	25	33	43	68
4	21	45	25	33	46	78
5	18	39	17	30	35	69
6	15	39	21	30	36	69
7	16	35	17	31	33	65
8	12	35	11	27	23	62
9	15	39	19	21	34	60
10	16	35	27	22	43	67
11	14	35	27	31	41	66
12	13	31	25	31	38	62

CONTROL GROUP						
S.NO	PRE ADAPTIVE STRATEGY	POST ADAPTIVE STRATEGY	PRE MALADAPTIVE STRATEGY	POST MALADAPTIVE STRATEGY	PRE TOTAL	POST TOTAL
1	15	29	23	29	38	58
2	13	28	19	28	32	56
3	17	34	26	29	43	63
4	17	31	23	30	40	61
5	22	26	26	31	48	57
6	13	24	28	30	38	54
7	23	31	22	29	47	60
8	10	39	24	28	22	67
9	17	44	16	25	33	69
10	9	38	22	32	31	70

KMCH ETHICS COMMITTEE
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EC Reg. No : ECR / 112 / Inst / TN / 2013

Ref: EC/AP/553/08/2017
07.08.2017

To

APPROVED

Dr.D. Srinivasan,

Head of the Department,

Consultant – psychiatrist,

Kovai Medical Center and Hospital,

Coimbatore-641 014,

Tamilnadu, India.

Dear Dr.D. Srinivasan,

The proposal entitled **"Effectiveness of Social Stories for Children with Childhood Psychiatry Conditions in Copying with Bullying"** submitted by **Ms. Sakthi Srija.S** under your supervision was reviewed by the Ethics Committee in its meeting held on **05.08.2017** and permission is granted to carry out the study at **Kovai Medical Center and Hospital Ltd, Coimbatore, India.**

Thanking you,

Yours faithfully,

Dr. P. R. Muthuswamy 07/08/17
Chairman, KMCH Ethics Committee

Dr. P. R MUTHUSWAMY,
MA ,MEA FDPM(IIM-A)Ph.D.,
Chairman
Ethics Committee
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KMCH ETHICS COMMITTEE
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EC Reg. No : ECR / 112 / Inst / TN / 2013

KMCH ETHICS COMMITTEE MEMBERS LIST

S. NO	MEMBER NAME	DESIGNATION	REPRESENTATION	DESIGNATION TO THE INSTITUTION	GENDER
1.	Dr.P.R.Muthuswamy	Principal, Dr.N.G.P Arts & Science College	Chairperson	Chairperson, KMCH Ethics Committee	M
2	Dr. Devdas Madhavan	Consultant Urologist	Member Secretary	Consultant Urologist	M
3	Dr. V.Rajamani	Consultant Rheumatologist & Physician	Clinician	Consultant Rheumatologist & Physician	M
4	Dr.K.Senthilkumar	MD-Pharmacology Pharmacologist	Basic Medical Scientist	None	M
5	Dr. A.N.Murugan	Medical Director	Clinician	Medical Director	M
6	Dr. Sangita S.Mehta	Consultant Pathologist	Clinician	Consultant Pathologist	F
7	Dr. S.Madhavi	Principal	Member	Principal, KMCH college of Nursing	F
8	Dr. K.S.G.Arul Kumaran	Professor	Basic Medical Scientist	Professor, KMCH college of Pharmacy	M
9	Dr. S.Thamil Selvi	Social Worker	Social worker	None	F
10	Mr. C.Tamil Selvan	VP-Materials	convener	VP-Materials	M
11	Mr. T.C.Dinamani	Advocate	Legal Expert	Personnel Manager	M
12	Mr.R.Krishnamoorthy	Priest	Theologist	Priest	M
13	Mr. D.Ramanathan	Office Assistant	Lay person	Office Assistant	M

7/8/17

Dr. P. R. Muthuswamy
Chairman, Ethics Committee

Dr. P. R. MUTHUSWAMY,
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10th July, 2017

Ref: RC/006/2017

To

Dr.D.Srinivasan,
Head of the Department,
Consultant – Psychiatrist,
Kovai Medical Center and Hospital,
Coimbatore-641014,
Tamilnadu, India.

Dear Dr. D.Srinivasan,

The dissertation work titled "**Effectiveness of Social Stories for Children with Childhood Psychiatry Conditions in Copying with Bullying**" presented by **Ms.Sakthi Srija.S,** 2nd year Master of Occupational Therapy under your guidance was discussed at Research Committee held on 05.08.2017 and unanimously decided to give permission to carry on the study at **Kovai Medical Center and Hospital Ltd, Coimbatore**, India.

Thanking you

Yours faithfully,

DR V.KUMARAN
11/08/2017
Head of the Institute/ Dean

Dr. V. KUMARAN MS., MCh.,
DEAN
Kovai Medical Center and Hospital
Coimbatore - 641 014 Tamil Nadu

Enclosure: Composition of Research Committee

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KMCH RESEARCH COMMITTEE MEMBERS LIST

S:NO	NAME	DESIGNATION
1	Dr.V.Kumaran	Head of the Institute/Dean
2	Dr. D.Srinivasan	Guide
3	Dr.Deepak.T	Basic Science Faculty
4	Dr.V.Ganesh	Statistician
5	Dr.Pankaj Mehta	Member
6	Dr.Arul Selvan.V	Member
7	Dr.K.S.Rajkumar	Member
8	Dr.N.Selvarajan	Member
9	Dr.Rajendran.K	Member

DR.V.KUMARAN
11/08/2017

Head of the Institute/Dean

Dr. V. KUMARAN MS., MCh.,
DEAN
Kovai Medical Center and Hospital
Coimbatore - 641 014 Tamil Nadu

EXCELLENCE IN HEALTH CARE 25 1990 - 2015

KMCH COLLEGE OF OCCUPATIONAL THERAPY

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June 19, 2017

To

Dr. D. Srinivasan
M.D. D.P.M
Consultant Psychological Medicine
KMCH, CBE

Respected Sir / Madam,

Sub: Permission to conduct a study.

* * *

I would like to bring to your kind notice that one of our M.O.T student **Ms. Sakthi Srija.S** of II year, is doing a project title **"Effectiveness of Social Stories for Children with Childhood Psychiatry Conditions in Coping with Bullying "** Therefore, I request you to kindly grant her permission to do the study.

Thanking You,

Yours Sincerely,

19/6/17

Mrs. Sujata Missal, M.Sc (OT).,
Principal.

19.6.17

Administrative Office :
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June 19, 2017

To

Dr. Chitra Jayakumar
M.B.B.S, DCP, MRCPsych
Consultant Psychiatrist
KMCH, CBE

Respected Sir / Madam,

Sub: Permission to conduct a study.

* * *

I would like to bring to your kind notice that one of our M.O.T student **Ms. Sakthi Srija.S** of II year, is doing a project title **"Effectiveness of Social Stories for Children with Childhood Psychiatry Conditions in Coping with Bullying "** Therefore, I request you to kindly grant her permission to do the study.

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E-mail : info@kmch.ac.in website : www.kmch.ac.in

St.John's
Matriculation Higher Secondary School

TO WHOMSOEVER IT MAY CONCERN

Respected Sir/Madam,

This is to certify that **Ms. Sakthi Srija. S a student of M. O. T (Master of Occupational Therapy II Year), KMCH college of Occupational therapy, Coimbatore,** has successfully done her project on **"Effectiveness of Social Stories for Children with Childhood Psychiatry Condition in copying with Bullying",** in our institution for a period of 2 months (13 Sessions) (From 25/09/2017 – 30/11/2017). During the period of her study with us, she was found hardworking & inquisitive.

We wish her every success in life.

Place: Coimbatore

Date: 10/1/2018

Signature

10.1.18

PRINCIPAL
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